

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0037762</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Albany Care Inc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>901 Maple</u> <u>Evanston</u> <u>60202</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 475-4000</u> Fax # <u>(847) 475-8316</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
Paid Preparer	(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u>																								
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																								
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																								
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>11/01/91</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☒ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	417	Intermediate (ICF)	417	152,622	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,622	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					8
9	SNF/PED					9
10	ICF	134,469	2,046	397	136,912	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	134,469	2,046	397	136,912	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.71%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? 1,302 (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)
None

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 1/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1/1/1991 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	402,556	56,495	68,088	527,139		527,139	(35,630)	491,509			1
2	Food Purchase		567,485		567,485	(19,471)	548,014	(84)	547,929			2
3	Housekeeping	320,026	87,340		407,366		407,366		407,366			3
4	Laundry		24,144	36,116	60,260		60,260		60,260			4
5	Heat and Other Utilities			307,513	307,513		307,513	(10,313)	297,200			5
6	Maintenance	65,835	66,660	238,890	371,385		371,385	32,816	404,201			6
7	Other (specify):*							14,663	14,663			7
8	TOTAL General Services	788,417	802,124	650,607	2,241,148	(19,471)	2,221,677	1,452	2,223,128			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,832,052	74,950	212,595	3,119,597		3,119,597	(52,200)	3,067,397			10
10a	Therapy	74,518		50,040	124,558		124,558	(25,962)	98,596			10a
11	Activities	453,635	30,587		484,222		484,222		484,222			11
12	Social Services	531,938		7,200	539,138		539,138		539,138			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,020	12,020			15
16	TOTAL Health Care and Programs	3,892,143	105,537	273,435	4,271,115		4,271,115	(66,142)	4,204,973			16
	C. General Administration											
17	Administrative	229,864		978,150	1,208,014		1,208,014	(732,141)	475,873			17
18	Directors Fees											18
19	Professional Services			315,761	315,761	(17,288)	298,473	(213,766)	84,707			19
20	Dues, Fees, Subscriptions & Promotions			106,352	106,352		106,352	(67,764)	38,588			20
21	Clerical & General Office Expenses	387,424	105,256	181,630	674,310		674,310	137,759	812,069			21
22	Employee Benefits & Payroll Taxes			910,655	910,655	19,471	930,126	(7,200)	922,926			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,556	7,556		7,556	(3,787)	3,769			24
25	Other Admin. Staff Transportation			20,689	20,689		20,689	13,163	33,852			25
26	Insurance-Prop.Liab.Malpractice			273,241	273,241		273,241	30,281	303,522			26
27	Other (specify):*							96,962	96,962			27
28	TOTAL General Administration	617,288	105,256	2,794,034	3,516,578	2,184	3,518,762	(746,493)	2,772,269			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,297,848	1,012,917	3,718,076	10,028,841	(17,288)	10,011,553	(811,183)	9,200,370			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			170,555	170,555		170,555	567,106	737,661			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,832	49,832		49,832	1,814,396	1,864,228			32
33	Real Estate Taxes					17,288	17,288	519,210	536,498			33
34	Rent-Facility & Grounds			3,777,000	3,777,000		3,777,000	(3,777,000)				34
35	Rent-Equipment & Vehicles			21,322	21,322		21,322	4,809	26,131			35
36	Other (specify):*							193,968	193,968			36
37	TOTAL Ownership			4,018,709	4,018,709	17,288	4,035,997	(677,511)	3,358,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,050,439	1,050,439		1,050,439		1,050,439			42
43	Other (specify):*			60,000	60,000		60,000	(60,000)				43
44	TOTAL Special Cost Centers			1,110,439	1,110,439		1,110,439	(60,000)	1,050,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,297,848	1,012,917	8,847,224	15,157,989		15,157,989	(1,548,695)	13,609,294			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,181)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	138,058	30		9
10	Interest and Other Investment Income	(44,625)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(84)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(28,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,273)	21		24
25	Fund Raising, Advertising and Promotional	(2,891)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,800)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(181,962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,859)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,403,836)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,403,836)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,548,695)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Albany Care Inc

	ID#	0037762
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rental Income - Misc. Income	\$ (1,200)	21	1
2	Jury Duty - Misc. Income	(338)	21	2
3	Other Professional Fees	(433)	19	3
4	Bank Charges	(5,944)	21	4
5	Non-Allowable Expense	(60,000)	43	5
6	Collections	(1,099)	21	6
7	Alliance for Living - PAC Committee	(37,734)	20	7
8	Capitalized R&M	(6,172)	06	8
9	Non-Allowable Legal	(9,708)	19	9
10	Misc Income	(668)	21	10
11				11
12				12
13				13
14	Amortization - Bldg. Company	(10,984)	36	14
15	Filing Fees - Bldg Company	(400)	20	15
16	Replacement Tax - Bldg Company	(4,475)	21	16
17	Professional Fees - Bldg Company	(7,500)	19	17
18	Office Expense-Bldg Company	(10)	21	18
19	Capitalized R&M-Bldg Company	(35,297)	06	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	(181,962)		49

Albany Care Inc

Report Period Beginning:

Ending:

ID#

0037762

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	34	Rent	\$ 3,777,000	Albany Care, LLC		\$	\$(3,777,000)	1
2	V	36	Amortization		Albany Care, LLC		10,984	10,984	2
3	V	06	Repairs and Maintenance		Albany Care, LLC		107,222	107,222	3
4	V	30	Depreciation		Albany Care, LLC		410,461	410,461	4
5	V	20	Filing Fees		Albany Care, LLC		400	400	5
6	V	32	Mortgage Interest		Albany Care, LLC		1,862,092	1,862,092	6
7	V	36	MIP		Albany Care, LLC		193,968	193,968	7
8	V	21	Office Expense		Albany Care, LLC		10	10	8
9	V	19	Professional Fees		Albany Care, LLC		7,500	7,500	9
10	V	26	Property Insurance		Albany Care, LLC		27,016	27,016	10
11	V	33	Real Estate Taxes		Albany Care, LLC		511,858	511,858	11
12	V	32	Interest Income	269	Albany Care, LLC			(269)	12
13	V	21	Replacement Tax		Albany Care, LLC		4,475	4,475	13
14	Total			\$ 3,777,269			\$ 3,135,986	\$ * (641,283)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	6	REPAIRS AND MAINT.	\$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	\$ 17,813	\$ (32,227)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,395	1,395	16
17	V	10	NURSING	100,080	S.I.R. MANAGEMENT, INC.	100.00%	31,953	(68,127)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	5,375	5,375	18
19	V	19	PROFESSIONAL FEES	261,180	S.I.R. MANAGEMENT, INC.	100.00%	26,100	(235,080)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	961	961	20
21	V	21	CLERICAL & GENERAL	100,080	S.I.R. MANAGEMENT, INC.	100.00%	121,875	21,795	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,313	1,313	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	19,763	19,763	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	3,008	3,008	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,565	21,565	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(16,531)	(16,531)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	12,609	12,609	27
28	V								28
29	V	17	ADMINISTRATIVE	948,150	S.I.R. MANAGEMENT, INC.	100.00%	54,443	(893,707)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	450	450	30
31	V	21	CLERICAL & GENERAL	70,380	S.I.R. MANAGEMENT, INC.	100.00%	205,518	135,138	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	40,167	40,167	32
33	V	6	REPAIRS AND MAINT.	5,700				(5,700)	33
34	V	22	EMPLOYEE BENEFITS	7,200				(7,200)	34
35	V	24	SEMINARS	5,100				(5,100)	35
36	V	25	TRAVEL	6,600				(6,600)	36
37	V	35	EQUIPMENT RENTAL	3,300				(3,300)	37
38	V	35	AUTO LEASE	4,500				(4,500)	38
39	Total			\$ 1,562,310			\$ 547,777	\$ * (1,014,533)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	1	DIETARY SALARIES	\$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	\$ 14,410	\$ (35,630)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,444	2,444	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	15,927	15,927	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	2,680	2,680	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	161,566	161,566	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	30,890	30,890	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	35,230	35,230	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	50,040	S.I.R. MANAGEMENT, INC.	100.00%	24,078	(25,962)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,965	3,965	25
26	V								26
27	V	6	MAINTENANCE SALARIES	55,660	S.I.R. MANAGEMENT, INC.	100.00%	59,519	3,859	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	10,824	10,824	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	4,868	4,868	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,131	1,131	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	115	115	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	148	148	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	257	257	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	18,587	18,587	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	13,729	13,729	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,352	7,352	37
38	V								38
39	Total			\$ 155,740			\$ 407,720	\$ * 251,980	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 133,857	\$ 133,857	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	133,857	CCS Employee Benefits Group	100.00%		(133,857)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 133,857			\$ 133,857	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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	ADAM VALES TRUST	1.199%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	ALBANY CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ARI WOLFF	1.439%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRO TRUST	2.644%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	7.314%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	CELESTE GIANNINI TRUST DTD 3/13/00	7.314%	ELMWOOD CARE, INC.	ELMWOOD PARK				5
6	CHARLENE HILL -JEON	0.480%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	CHERYL MAGENCE	1.439%	GREENWOOD CARE, INC.	EVANSTON				7
8	DANIEL ROTHNER	0.719%	MAPLEWOOD CARE, INC.	ELGIN				8
9	DANIEL ROTHNER TRUST	1.199%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	DENNIS TOSSI	3.118%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	ELLIOTT AND RONNIE ROBINSON	2.386%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	ERIC ROTHNER	4.556%	WILSON CARE, INC.	CHICAGO				12
13	FREDA ROBINSON TRUST DTD 10/21/83	4.374%						13
14	GLENDA STRICKLAND	1.918%						14
15	HARVEY SCOTT	0.480%						15
16	JEFF ORAVEC	0.480%						16
17	JULIANA BARRISH TRUST DATED 1/26/93	7.314%						17
18	KATHRYN VALES TRUST	1.199%						18
19	LAURI WOLFF POLEN	1.439%						19
20	LOUISE BERGTHOLD	0.719%						20
21	MARILYN WOLFF REVOCABLE TRUST	4.357%						21
22	MELISSA ROTHNER	0.719%						22
23	MELISSA ROTHNER TRUST	1.199%						23
24	MICHAEL R GIANNINI TRUST DTD 3/13/00	7.314%						24
25	NOAH WOLFF REVOCABLE TRUST	4.357%						25
26	RANAN WOLFF	1.439%						26
27	PATRICIA MCDIARMID	0.480%						27
28	RACHEL ROTHNER	0.719%						28
29	RACHEL ROTHNER TRUST	1.199%						29
30								30

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	SHELDON ROBINSON TRUST DTD 11/14/77	4.374%						1
2	SHELDON ROBINSON-LEVITT FAMILY TRUST	2.386%						2
3	STEVE AND BARBARA GELLER	2.386%						3
4	THE ESTATE OF NORMAN MATTHEW	7.953%						4
5	THOMAS WINTER	0.719%						5
6	TZIONA ZEFFREN	1.439%						6
7	WILLIAM ROTHNER	0.719%						7
8	WILLIAM ROTHNER TRUST	1.199%						8
9	EDWARD MATTHEW	1.439%						9
10	KENNETH MATTHEW	1.439%						10
11	SAMUEL MATTHEW/BRO TRUST	1.439%						11
12	HARRISON MATTHEW/BRO TRUST	1.439%						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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Dennis Tossi	Owner	Administrative	3.11	See Attached	40	100.00%	Salary	\$ 137,612	17-1	1
2	Bryan Barrish	Relative	Administrative	N/A	See Attached	6.42	14.27%	Alloc. Salary	32,102	17-7	2
3	Michael Giannini	Relative	Administrative	N/A	See Attached	5.62	14.05%	Fee/Alloc.Sal	56,965	17-3;17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	8.03	16.06%	Alloc. Salary	14,410	1-7	4
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	8.03	16.06%	Alloc. Salary	19,411	17-7	5
6	Kirsten Barrish	Relative	Clerical	N/A	See Attached	6.42	16.05%	Alloc. Salary	7,479	21-7	6
7	Jeff Oravec	Owner	Administrative	0.48	See Attached	6.42	16.05%	Alloc. Salary	22,341	17-7	7
8	Louise Bergthold	Owner	Administrative	0.72	See Attached	9.63	16.05%	Alloc. Salary	32,102	17-7	8
9	Patricia McDiarmid	Owner	Administrative	0.48	See Attached	8.03	16.06%	Alloc. Salary	22,100	17-7	9
10	Tom Winter	Owner	Administrative	0.72	See Attached	9.63	16.05%	Alloc. Salary	32,102	17-7	10
11	Adam Vales	Owner	Clerical	1.20	See Attached	0.89	2.23%	Alloc. Salary	1,625	22-7	11
12	See second page 7 for the detail of the additional owner and related compensation										12
13								TOTAL	\$ 378,249		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	852,976	13	\$ 110,978	\$ 47,841	136,912	\$ 17,813	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		136,912	1,395	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	136,912	31,953	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		136,912	5,375	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	136,912	26,100	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		136,912	961	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	136,912	121,875	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		136,912	1,313	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		136,912	19,763	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		136,912	3,008	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		136,912	21,565	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		136,912	(16,531)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		136,912	12,609	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	136,912	54,443	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		136,912	450	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	136,912	205,518	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		136,912	40,167	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 547,777	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY SALARIES	PATIENT DAYS	852,976	13	\$ 89,778	\$ 89,778	136,912	\$ 14,410	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		136,912	2,444	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	136,912	15,927	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		136,912	2,680	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	136,912	161,566	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		136,912	30,890	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		136,912	35,230	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	50,040	24,078	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		50,040	3,965	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	55,660	59,519	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		55,660	10,824	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		2,067	4,868	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		2,067	1,131	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		2,067	115	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		2,067	148	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		2,067	257	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		2,067	18,587	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		2,067	13,729	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		2,067	7,352	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 407,720	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 133,857	1
2										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	TOTALS					\$	\$		\$ 133,857	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	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						\$	\$			1
2										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	TOTALS					\$	\$		\$	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
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										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					\$	\$		\$	25

Ending: 12/31/12**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			1
2										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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge Capital		X	Mortgage			\$	38,563,964			\$	1,862,092	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				1,300,000				49,832	6
7	Alloc. -SIR Management	X										13,729	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	39,863,964			\$	1,925,653	9
	B. Non-Facility Related*												
10	Alloc. -SIR Management	X										(16,531)	10
11	Interest Income		X									(44,625)	11
12	Interest Income - Bldg. Co.	X										(269)	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(61,425)	14
15	TOTALS (line 9+line14)						\$	39,863,964			\$	1,864,228	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 193,968 Line # 36

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	532,000	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.)		\$	516,210	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(15,790)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	535,000	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.		\$	17,288	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 \$51,118;668 For 02/07 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.		\$	536,498	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	546,714	8	
		2008	567,685	9	
		2009	458,690	10	
		2010	506,302	11	
		2011	508,858	12	
Accrual = \$508,858 x 1.05 = \$535,000 (Rounded)				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
Alloc. -SIR Management: \$7,352				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.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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? X YES NO

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

C. Tax Bills

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

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

211,753

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

7

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).

None

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	Facility	24,573		\$ 84,558	1
2					2
3	TOTALS	24,573		\$ 84,558	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	417		1991	1972	\$ 7,267,981	\$ 303,864	20	\$ 363,399	\$ 59,535	\$ 7,132,463	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		61,428		20	3,071	3,071	59,487	9
10	Various		1994		120,534		20	6,025	6,025	110,673	10
11	Various		1995		291,499		20	14,331	14,331	250,261	11
12	Various		1996		58,666		20	2,933	2,933	48,458	12
13	Various		1997		72,445		20	3,505	3,505	55,787	13
14	Various		1998		177,216		20	8,861	8,861	130,326	14
15	Various		1999		239,104		20	11,955	11,955	158,565	15
16	Various		2000		239,704		20	11,615	11,615	149,602	16
17	Various		2001		370,037		20	14,996	14,996	255,512	17
18	Various		2002		887,772		20	22,422	22,422	274,581	18
19	Various		2003		489,239		20	43,624	43,624	432,118	19
20	Various		2004		261,729		20	13,086	13,086	112,873	20
21	Various		2005		211,692		20	10,585	10,585	80,043	21
22	Various		2006		47,928		20	2,652	2,652	17,062	22
23	Various		2007		752,722		20	37,949	37,949	211,313	23
24	Various		2008		15,271		20	974	974	4,387	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

*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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	2,289,387	50,618		119,084	68,466	428,405	67
68	Related Party Allocations (Pages 12H & 12I)	314,184	9,784		12,008	2,224	143,344	68
69	Financial Statement Depreciation		170,555			(170,555)		69
70	TOTAL (lines 4 thru 69)	\$ 14,168,538	\$ 534,821		\$ 703,074	\$ 168,253	\$ 10,055,258	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	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		\$ 14,168,538	\$ 534,821		\$ 703,074	\$ 168,253	\$ 10,055,258	1
2 Handrails	2009	11,410		20	571	571	1,759	2
3 Sewage And Pipeline	2009	8,300		20	415	415	1,660	3
4 Boiler Work	2009	3,427		20	171	171	657	4
5 Garage Door And Frame	2009	3,200		20	160	160	520	5
6 Boiler Repair	2010	4,295		20	215	215	447	6
7 Fire Rated Doors	2011	15,360		20	768	768	896	7
8 Condensate Tank Repair	2011	2,853		20	285	285	309	8
9 Cast Iron Pipe Repair	2011	2,875		20	288	288	311	9
10 Masonry Installations	2011	5,500		20	550	550	596	10
11 Ground Door Board Repair	2011	5,799		20	580	580	628	11
12 Replaced Steam Traps	2011	8,475		20	847	847	918	12
13 Replace Compressor 1&2 On Dining Rm Unit	2012	3,572		20	179	179	179	13
14 Drain Repairs	2012	2,600		20	130	130	130	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)		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	1
2									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	TOTAL (lines 1 thru 33)		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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 12C, Carried Forward		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	1
2								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 TOTAL (lines 1 thru 33)		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		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 12D, Carried Forward		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	1
2									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	TOTAL (lines 1 thru 33)		\$ 14,246,204	\$ 534,821		\$ 708,233	\$ 173,412	\$ 10,064,269	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	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 Building Company Information								1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Tile Flooring	2008	9,598		20	480	480	2,400	9
10 Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2008	403,200		20	20,160	20,160	100,800	10
11 Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2008	288,000		20	14,400	14,400	72,000	11
12 Bathtub Liners	2008	10,850		20	543	543	2,713	12
13 Bathtub Liners	2008	29,600		20	1,480	1,480	7,400	13
14 Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2009	124,950		20	9,128	9,128	36,510	14
15 Bathtub Liners	2009	14,125		20	706	706	2,825	15
16 Carpeting	2009	291,929		20	14,596	14,596	58,386	16
17 Roofing & Coating	2010	17,500		20	875	875	2,625	17
18 Driveway Concrete	2010	13,000		20	650	650	1,950	18
19 Tuckpointing & Chimney	2010	226,755		20	11,338	11,338	34,013	19
20 Fire Doors	2010	13,020		20	651	651	1,953	20
21 Building Improvements- Lighting 2nd Floor Laundry	2010	4,720		20	236	236	708	21
22 HVAC Upgrade	2010	200,420		20	10,021	10,021	30,063	22
23 Laundry Room- Drain Waste/ Vent and Gas Piping	2010	14,125		20	706	706	2,119	23
24 Lintel Replacement	2010	20,000		20	1,000	1,000	3,000	24
25 Admin Office- Pegasus Custom Furniture	2010	11,255		20	563	563	1,688	25
26 Boiler Work	2010	13,290		20	665	665	1,995	26
27 Lighting- Rooms	2010	82,400		20	4,120	4,120	12,360	27
28 Oxygen Rooms- Lighting, Exhaust fan, Duct work	2010	7,200		20	360	360	1,080	28
29 Window Treatments	2010	11,109		20	555	555	1,666	29
30 Window Treatments	2010	5,475		20	274	274	821	30
31 Window Treatments	2010	7,690		20	385	385	1,154	31
32 Building Improvements-Nurse Station Work	2010	12,000		20	600	600	1,800	32
33								33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Paint Basement Ceiling	2010	12,600		20	630	630	1,890	2
3	Tuckpointing	2010	3,000		20	150	150	450	3
4	Satellite System Wiring & Installation	2010	11,682		20	584	584	1,752	4
5	Duct Heater	2010	3,492		20	175	175	524	5
6	Kitchen Sink & Faucet	2011	2,882		20	144	144	288	6
7	Painting Basement Ceiling	2011	12,600		20	2,676	2,676	5,352	7
8	Carpeting	2011	3,931		20	190	190	380	8
9	Steam Traps	2011	8,810		20	135	135	270	9
10	Window Treatment - Admin	2011	2,738		20	137	137	274	10
11	Door Locks	2011	15,141		20	757	757	1,514	11
12	Ceiling Grid Replacement	2011	191,786		20	9,589	9,589	19,179	12
13	Television Wiring	2011	25,463		20	1,273	1,273	2,546	13
14	Smoke Tower Project	2011	69,599		20	3,480	3,480	6,960	14
15	Replace Window Air Conditioners	2011	3,801		20	190	190	380	15
16	Catch Basin, Drains in Bathrooms	2011	2,700		20	135	135	270	16
17	Custom Built in Furniture	2012	5,000		20	250	250	250	17
18	Metal Doors	2012	46,654		20	2,333	2,333	2,333	18
19	Vent and Boiler Pumps	2012	3,487		20	174	174	174	19
20	Garage Ceilings	2012	3,350		20	168	168	168	20
21	Plaster/Paint Dining Room	2012	8,200		20	410	410	410	21
22	Kitchen Floor Tiles	2012	9,072		20	454	454	454	22
23	Floor Repairs	2012	3,208		20	160	160	160	23
24	Replace Sprinklers	2012	5,030		20	252	252	252	24
25	Loading Dock Repairs	2012	2,950		20	148	148	148	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33				50,618			(50,618)		33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 2,289,387	\$ 50,618		\$ 119,084	\$ 68,466	\$ 428,405	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>SIR Properties - SIR Management</u>	2009	40,123		35	1,029	1,029	3,129	3
4	<u>SIR Properties - SIR Management</u>	1993	72,650	2,306	35	2,076	(230)	40,476	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Alloc. - S.I.R. Management</u>	1993	18,419	513	20	913	400	18,262	9
10	<u>Alloc. - S.I.R. Management</u>	1994	57		20			57	10
11	<u>Alloc. - S.I.R. Management</u>	1995	421		20	21	21	367	11
12	<u>Alloc. - S.I.R. Management</u>	1997	28,302	634	20	1,388	754	22,318	12
13	<u>Alloc. - S.I.R. Management</u>	1999	2,225		20	111	111	1,474	13
14	<u>Alloc. - S.I.R. Management</u>	1999	23,330		20			23,330	14
15	<u>Alloc. - S.I.R. Management</u>	2000	2,627		20	131	131	1,647	15
16	<u>Alloc. - S.I.R. Management</u>	2007	8,442	576	20	422	(154)	2,192	16
17	<u>Alloc. - S.I.R. Management</u>	2008	23,265	2,223	20	1,466	(757)	7,104	17
18	<u>Alloc. - S.I.R. Management</u>	2009	57,811	529	20	2,890	2,361	9,378	18
19	<u>Alloc. - S.I.R. Management</u>	2011	1,430	143	20	143		203	19
20	<u>Alloc. - S.I.R. Management</u>	2012	4,577	95	20	95		95	20
21									21
22	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2012	4,450	2,367	20	20	(2,347)	20	22
23	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2010	4,384		20	219	219	511	23
24	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2009	4,362	272	20	218	(54)	829	24
25	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2007	1,272	102	20	64	(38)	382	25
26	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2002	288		20	14	14	152	26
27	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1999	9,206		20	460	460	6,214	27
28	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1998	4,399		20	220	220	3,189	28
29	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1997	274		20	14	14	226	29
30	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1994	692	18	20	35	17	640	30
31	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1993	1,178	6	20	59	53	1,149	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		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	Related Party Information Continued								1
2									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	TOTAL (12H & 12I lines 1 thru 33)		\$314,184	\$9,784		\$12,008	\$2,224	\$143,344	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$663,772	\$31,466	\$27,686	\$(3,780)	10	\$346,669	71
72	Current Year Purchases	58,233	29,150	885	(28,265)	10	885	72
73	Fully Depreciated Assets	1,118,466				10	1,118,466	73
74								74
75	TOTALS	\$1,840,471	\$60,616	\$28,571	\$(32,045)		\$1,466,020	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	Facility	Chevy Express Van	2010	\$35,076	\$3,367		\$(3,367)	5		76
77		Allocated from SIR Management	2011	5,642	798	856	58	5	1,973	77
78										78
79										79
80	TOTALS			\$40,718	\$4,165	\$856	\$(3,309)		\$1,973	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$16,211,951	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$599,602	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$737,660	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$138,058	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$11,532,262	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: N/A
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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 26,131
- Description: See Attached Schedule

(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
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 46,224	\$ 458,533	1
2	Cash-Patient Deposits	64,296	64,296	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,881,140	2,881,140	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,525	66,792	6
7	Other Prepaid Expenses	31,901	31,901	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,088,086	\$ 3,502,662	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,353,887	5,672,951	15
16	Equipment, at Historical Cost	2,350,159	2,980,030	16
17	Accumulated Depreciation (book methods)	(3,409,835)	(8,850,615)	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): See Attached Schedule	263,583	1,368,970	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,557,794	\$ 8,523,875	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,645,880	\$ 12,026,537	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 268,940	\$ 340,393	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,226	104,226	28
29	Short-Term Notes Payable	1,300,000	1,300,000	29
30	Accrued Salaries Payable	516,330	516,330	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,243	14,243	31
32	Accrued Real Estate Taxes(Sch.IX-B)		535,000	32
33	Accrued Interest Payable		154,256	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,400	28,400	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	415,292	415,292	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,647,431	\$ 3,408,140	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		38,563,964	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 38,563,964	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,647,431	\$ 41,972,104	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,998,449	\$ (29,945,567)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,645,880	\$ 12,026,537	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,885,117	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,885,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	446,928	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	(333,600)	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)	\$ 113,328	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,998,449	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 15,506,968	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,506,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,625	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,625	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	53,324	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 53,324	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,604,917	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,241,148	31
32	Health Care	4,271,115	32
33	General Administration	3,516,578	33
	B. Capital Expense		
34	Ownership	4,018,709	34
	C. Ancillary Expense		
35	Special Cost Centers	60,000	35
36	Provider Participation Fee	1,050,439	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,157,989	40
41	Income before Income Taxes (line 30 minus line 40)**	446,928	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 446,928	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 15,254,778	44
45	Private Pay - Net Inpatient Revenue	252,190	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,506,968	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete 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.

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	1,953	2,091	\$ 115,104	\$ 55.05	1
2	Assistant Director of Nursing	3,223	3,703	116,566	31.48	2
3	Registered Nurses	2,190	2,258	71,093	31.48	3
4	Licensed Practical Nurses	37,245	40,749	957,781	23.50	4
5	CNAs & Orderlies	111,944	121,335	1,393,290	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,845	8,598	74,518	8.67	8
9	Activity Director	3,757	4,183	92,927	22.22	9
10	Activity Assistants	35,137	37,386	360,708	9.65	10
11	Social Service Workers	32,975	35,467	531,938	15.00	11
12	Dietician					12
13	Food Service Supervisor	1,829	2,091	60,669	29.01	13
14	Head Cook	3,549	4,072	54,487	13.38	14
15	Cook Helpers/Assistants	24,094	26,195	287,400	10.97	15
16	Dishwashers					16
17	Maintenance Workers	5,142	5,544	65,835	11.88	17
18	Housekeepers	28,121	30,606	320,026	10.46	18
19	Laundry					19
20	Administrator	1,721	2,043	137,612	67.36	20
21	Assistant Administrator	3,500	3,974	92,252	23.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,531	28,806	387,424	13.45	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	7,310	7,968	178,218	22.37	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	338,066	367,069	\$ 5,297,848 *	\$ 14.43	34

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	Monthly	\$ 68,088	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	100,080	10-03	38
39	Pharmacist Consultant	Monthly	26,191	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab	Monthly	50,040	10a-03	47
48	Psychiatric Director	Monthly	7,200	12-03	48
49	TOTAL (lines 35 - 48)		\$ 259,711		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	2,339	81,812	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,339	\$ 81,812		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Albany Care Inc		STATE OF ILLINOIS		Report Period Beginning:		01/01/12		Page 21	
				# 0037762				Ending:		12/31/12	
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name		Function	%	Amount	Description		Amount	Description		Amount	
Dennis Tossi		Administrator	3.11%	\$ 137,612	Workers' Compensation Insurance		\$ 72,600	IDPH License Fee		\$ 1,913	
Cynthia Schofield 1/1/12-10/23/12		Assist. Admin.	0.00%	40,414	Unemployment Compensation Insurance		75,719	Advertising: Employee Recruitment		660	
Elizabeth Webster 10/24/12-current		Assist. Admin.	0.00%	51,838	FICA Taxes		391,585	Health Care Worker Background Check			
					Employee Health Insurance		305,783	(Indicate # of checks performed 393)		3,936	
					Employee Meals		19,471	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Licenses and Permits		26,397	
					Pension		47,117	Dues and Subscriptions		4,721	
					401k Matching		7,550	Alloc. SIR Management		961	
					Employee Benefits - Other		3,101				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 229,864							
B. Administrative - Other											
Description				Amount				Less: Public Relations Expense		()	
S.I.R. Management - Consulting Fee				\$ 848,070				Non-allowable advertising		()	
S.I.R. Management - Dir of Admin Services				100,080				Yellow page advertising		()	
Director Fees - Michael Giannini				30,000				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,588	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 922,926				
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 978,150	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount	
Olympic Engineering		Engineering Services	\$ 1,500				\$	Out-of-State Travel		\$	
Pinnacle Consulting		Customer Satisfaction	3,755								
Legat Architects		Architectural Services	3,200								
Amari & Locallo		RE Tax Appeal	17,288					In-State Travel			
HK Payroll Services		WOTC	360								
Legal		See Schedule	11,882								
Schain, Burney, Banks & Kenny		adj pg 5a	433								
Plante Moran		Accounting	1,444					Seminar Expense		2,456	
SIR Management		Dir of Regulatory Services	50,040					Alloc. SIR Management		1,313	
SIR Management		Accounting	36,000								
SIR Management		Bookkeeping Fees	175,140								
See Supplemental Schedule			14,718					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 315,760				TOTAL		\$ 3,769	
						* Attach copy of IMRF notifications					
						**See instructions.					
SEE ACCOUNTANTS' COMPILATION REPORT											

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Alliance for Living - \$38,504
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 173 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ #####
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. \$ 19,471 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
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? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT