

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0037762

**Facility Name:** Albany Care

**Address:** 901 Maple Avenue Evanston 60202  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (847) 475-4000 **Fax #** (847) 475-8316

**HFS ID Number:** 363764987001

**Date of Initial License for Current Owners:** 11/01/91

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) \_\_\_\_\_

(Title) \_\_\_\_\_

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) Cary C. Buxbaum, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.  
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	<u>417</u>	Intermediate (ICF)	<u>417</u>	<u>152,205</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>417</u>	TOTALS	<u>417</u>	<u>152,205</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>137,475</u>	<u>529</u>	<u>379</u>	<u>138,383</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>137,475</u>	<u>529</u>	<u>379</u>	<u>138,383</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.92%

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

4,254 (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 01/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 10/01/91 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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	316,398	61,383	73,511	451,292		451,292	(36,056)	415,236			1
2	Food Purchase		443,640		443,640	(15,038)	428,602	(17)	428,585			2
3	Housekeeping	284,514	54,411		338,925		338,925	1,273	340,198			3
4	Laundry		29,995	24,799	54,794		54,794		54,794			4
5	Heat and Other Utilities			406,641	406,641		406,641	4,106	410,747			5
6	Maintenance	75,266	29,497	156,168	260,931		260,931	(29,377)	231,554			6
7	Other (specify):*							6,147	6,147			7
8	<b>TOTAL General Services</b>	<b>676,178</b>	<b>618,926</b>	<b>661,119</b>	<b>1,956,223</b>	<b>(15,038)</b>	<b>1,941,185</b>	<b>(53,923)</b>	<b>1,887,262</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,434,093	70,277	137,562	2,641,932		2,641,932	(65,128)	2,576,804			10
10a	Therapy	40,567		37,141	77,708		77,708	(13,226)	64,482			10a
11	Activities	409,733	19,343	2,650	431,726		431,726		431,726			11
12	Social Services	475,033			475,033		475,033		475,033			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,883	11,883			15
16	<b>TOTAL Health Care and Programs</b>	<b>3,359,426</b>	<b>89,620</b>	<b>180,953</b>	<b>3,629,999</b>		<b>3,629,999</b>	<b>(66,471)</b>	<b>3,563,528</b>			16
	<b>C. General Administration</b>											
17	Administrative	190,694		769,798	960,492		960,492	(562,148)	398,344			17
18	Directors Fees											18
19	Professional Services			238,537	238,537		238,537	(174,042)	64,495			19
20	Dues, Fees, Subscriptions & Promotions			103,556	103,556		103,556	(25,327)	78,229			20
21	Clerical & General Office Expenses	335,183	95,697	230,167	661,047		661,047	(121,688)	539,359			21
22	Employee Benefits & Payroll Taxes			690,458	690,458	15,038	705,496	(9,353)	696,143			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,467	5,467		5,467	(1,624)	3,843			24
25	Other Admin. Staff Transportation			21,024	21,024		21,024	470	21,494			25
26	Insurance-Prop.Liab.Malpractice			332,579	332,579		332,579	(1,577)	331,002			26
27	Other (specify):*							67,965	67,965			27
28	<b>TOTAL General Administration</b>	<b>525,877</b>	<b>95,697</b>	<b>2,391,586</b>	<b>3,013,160</b>	<b>15,038</b>	<b>3,028,198</b>	<b>(827,324)</b>	<b>2,200,874</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,561,481</b>	<b>804,243</b>	<b>3,233,658</b>	<b>8,599,382</b>		<b>8,599,382</b>	<b>(947,718)</b>	<b>7,651,664</b>			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.

Facility Name & ID Number Albany Care #0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			208,580	208,580		208,580	412,181	620,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			199,741	199,741		199,741	930,698	1,130,439			32
33	Real Estate Taxes			456,473	456,473		456,473	13,917	470,390			33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)				34
35	Rent-Equipment & Vehicles			23,117	23,117		23,117	5,274	28,391			35
36	Other (specify):*							19,855	19,855			36
37	<b>TOTAL Ownership</b>			2,626,402	2,626,402		2,626,402	(356,566)	2,269,836			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			228,308	228,308		228,308		228,308			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			228,308	228,308		228,308		228,308			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,561,481	804,243	6,088,368	11,454,092		11,454,092	(1,304,285)	10,149,807			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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	170,478	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(19,845)	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	(82,873)	21		24
25	Fund Raising, Advertising and Promotional	(4,143)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(25,510)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(81,474)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (43,384)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,260,901)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,260,901)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,304,285)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0037762  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1			1
2			2
3			3
4			4
5			5
6			6
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10			10
11			11
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95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(81,474)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(27,307)	(8,749)						(36,056)	1
2	Food Purchase	(17)											(17)	2
3	Housekeeping			1,334					(61)				1,273	3
4	Laundry													4
5	Heat and Other Utilities	(834)		1,765	3,175								4,106	5
6	Maintenance	(5,300)		1,588	(20,205)	167	(5,627)						(29,377)	6
7	Other (specify):*				2,118	2,891	1,138						6,147	7
8	<b>TOTAL General Services</b>	<b>(6,151)</b>		<b>4,687</b>	<b>(14,912)</b>	<b>(24,249)</b>	<b>(13,238)</b>		<b>(61)</b>				<b>(53,923)</b>	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(20,771)			(41,447)				(2,910)				(65,128)	10
10a	Therapy						(13,226)						(13,226)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				7,365		4,518						11,883	15
16	<b>TOTAL Health Care and Programs</b>	<b>(20,771)</b>			<b>(34,082)</b>		<b>(8,708)</b>		<b>(2,910)</b>				<b>(66,471)</b>	16
	<b>C. General Administration</b>													
17	Administrative			29,056	(29,315)	(546,289)	(15,600)						(562,148)	17
18	Directors Fees													18
19	Professional Services	(99)		(174,123)	589	33,371	(33,780)						(174,042)	19
20	Fees, Subscriptions & Promotions	(26,678)		468	883								(25,327)	20
21	Clerical & General Office Expenses	(156,447)	564	101,038	(1,318)	667	(66,192)						(121,688)	21
22	Employee Benefits & Payroll Taxes						(6,600)	(2,741)		(12)			(9,353)	22
23	Inservice Training & Education													23
24	Travel and Seminar			158	618		(2,400)						(1,624)	24
25	Other Admin. Staff Transportation			1,009	5,461		(6,000)						470	25
26	Insurance-Prop.Liab.Malpractice	(3,716)		556	1,163	420							(1,577)	26
27	Other (specify):*			18,240	10,116	39,609							67,965	27
28	<b>TOTAL General Administration</b>	<b>(186,940)</b>	<b>564</b>	<b>(23,598)</b>	<b>(11,803)</b>	<b>(472,222)</b>	<b>(130,572)</b>	<b>(2,741)</b>		<b>(12)</b>			<b>(827,324)</b>	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(213,862)</b>	<b>564</b>	<b>(18,911)</b>	<b>(60,797)</b>	<b>(496,470)</b>	<b>(152,518)</b>	<b>(2,741)</b>	<b>(2,971)</b>	<b>(12)</b>			<b>(947,718)</b>	29

STATE OF ILLINOIS

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	170,478	234,180	2,855	4,668								412,181	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		930,555	(914)	1,057								930,698	32
33	Real Estate Taxes			4,104	9,813								13,917	33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491)	34
35	Rent-Equipment & Vehicles			3,502	4,565	4,407	(7,200)						5,274	35
36	Other (specify):*		19,855										19,855	36
37	<b>TOTAL Ownership</b>	<b>170,478</b>	<b>(553,901)</b>	<b>9,547</b>	<b>20,103</b>	<b>4,407</b>	<b>(7,200)</b>						<b>(356,566)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(43,384)</b>	<b>(553,337)</b>	<b>(9,364)</b>	<b>(40,694)</b>	<b>(492,064)</b>	<b>(159,718)</b>	<b>(2,741)</b>	<b>(2,971)</b>	<b>(12)</b>			<b>(1,304,285)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Albany Care, LLC		Building

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,738,491	Albany Care, LLC		\$	\$ (1,738,491)	1
2	V	36 Amortization		Albany Care, LLC		19,855	19,855	2
3	V	30 Depreciation		Albany Care, LLC		234,180	234,180	3
4	V	32 Mortgage Interest		Albany Care, LLC		937,469	937,469	4
5	V	21 Office Expense		Albany Care, LLC		564	564	5
6	V	32 Interest Income	6,914				(6,914)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,745,405			\$ 1,192,068	\$ * (553,337)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 1,334	1,334	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,765	1,765	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,588	1,588	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	29,056	29,056	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,893	1,893	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	468	468	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	101,038	101,038	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	158	158	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,009	1,009	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	556	556	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	18,240	18,240	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,855	2,855	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(914)	(914)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	4,104	4,104	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,502	3,502	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	176,016	PREFERRED BOOKKEEPING	100.00%		(176,016)	32
33	V	19 COMPUTER	10,008	PREFERRED BOOKKEEPING	100.00%	10,008		33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 186,024			\$ 176,660	\$ * (9,364)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 3,175	3,175	15
16	V	6 REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	17,331	(20,205)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,118	2,118	17
18	V	10 NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	41,125	(41,447)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	7,365	7,365	19
20	V	17 ADMINISTRATIVE	52,548	S.I.R. MANAGEMENT, INC.	100.00%	23,233	(29,315)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	589	589	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	883	883	22
23	V	21 CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	41,222	(1,318)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	618	618	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,461	5,461	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,163	1,163	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,116	10,116	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,668	4,668	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	1,057	1,057	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	9,813	9,813	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,565	4,565	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 215,196			\$ 174,502	\$ * (40,694)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	\$ 42,540	S.I.R. MANAGEMENT, INC.	100.00%	\$ 15,233	(27,307)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,891	2,891	16
17	V	17	ADMIN./LEGAL SALARIES	659,025	S.I.R. MANAGEMENT, INC.	100.00%	101,603	(557,422)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	33,371	33,371	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	16,748	16,748	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	6,748	6,748	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	167	167	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	501	501	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	147	147	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	11,549	11,549	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	2,336	2,336	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	4,386	4,386	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	167	167	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	273	273	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	11,312	11,312	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	2,070	2,070	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 701,565				\$ 209,501	\$ * (492,064)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	10A SPECIAL REHAB	37,032	S.I.R. MANAGEMENT, INC.	100.00%	23,806	\$	(13,226)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	4,518		4,518	16
17	V								17
18	V	6 REPAIRS AND MAINT.	576	S.I.R. MANAGEMENT, INC.	100.00%	349		(227)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	66		66	19
20	V								20
21	V								21
22	V	1 DIETICIAN SALARIES	14,400	S.I.R. MANAGEMENT, INC.	100.00%	5,651		(8,749)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,072		1,072	23
24	V								24
25	V	19 LEGAL FEES	33,780	S.I.R. MANAGEMENT, INC.	100.00%			(33,780)	25
26	V								26
27	V	17 COUNCIL DUES	15,600	S.I.R. MANAGEMENT, INC.	100.00%			(15,600)	27
28	V								28
29	V	21 TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%			(66,192)	29
30	V	6 REPAIRS	5,400	S.I.R. MANAGEMENT, INC.	100.00%			(5,400)	30
31	V	35 EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%			(3,000)	31
32	V	35 AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%			(4,200)	32
33	V	25 TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%			(6,000)	33
34	V	24 SEMINARS	2,400	S.I.R. MANAGEMENT, INC.	100.00%			(2,400)	34
35	V	22 EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%			(6,600)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 195,180			\$ 35,462	\$ *	(159,718)	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 BENEFIT GROUP	100.00%	\$ 135,397	\$ 135,397	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	138,138	CCS EMPLOYEE BENEFIT GROUP	100.00%		(138,138)	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			\$ 138,138			\$ 135,397	\$ * (2,741)	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	01 DIETARY	\$	XCEL SUPPLY, LLC	100.00%	\$		15
16	V	03 HOUSEKEEPING	750	XCEL SUPPLY, LLC	100.00%	689	(61)	16
17	V	04 LAUNDRY		XCEL SUPPLY, LLC	100.00%			17
18	V	06 REPAIRS & MAINTENANCE		XCEL SUPPLY, LLC	100.00%			18
19	V	10 NURSING	35,884	XCEL SUPPLY, LLC	100.00%	32,974	(2,910)	19
20	V	11 ACTIVITIES		XCEL SUPPLY, LLC	100.00%			20
21	V	12 SOCIAL SERVICE		XCEL SUPPLY, LLC	100.00%			21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM		XCEL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL SUPPLY, LLC	100.00%			24
25	V	24 SEMINARS & EDUCATION		XCEL SUPPLY, LLC	100.00%			25
26	V	39 ANCILLARY		XCEL SUPPLY, LLC	100.00%			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		\$ 36,634			\$ 33,663	\$ * (2,971)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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 HEALTH INSURANCE	\$ 24,500	ECM OWNERS COUNCIL	100.00%	\$ 24,629	\$	129	15
16	V	17 ADMINISTRATOR SALARY	4,800	ECM OWNERS COUNCIL	100.00%	4,800			16
17	V	22 PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	459		(141)	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		\$ 29,900			\$ 29,888	\$ *	(12)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Bryan Barrish	Shareholder	Administrative	4.98%	See Attached	8.90	22.25%	Alloc. Sal/Mgt	\$ 19,248	17-3, 17-7	1
2	Mike Giannini	Shareholder	Administrative	4.98%	See Attached	13.34	33.35%	Alloc. Salary	4,386	17-7	2
3	Eric Rothner	Shareholder	Administrative	4.56%	See Attached	1.56	3.38%	Alloc. Sal/Mgt	51,224	17-3, 17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	11.13	22.26%	Alloc. Salary	15,233	1-7	4
5	Patricia McDiarmid	Shareholder	Administrative	0.48%	See Attached	11.13	22.26%	Alloc. Salary	23,233	17-7	5
6	Louise Bergthold	Shareholder	Administrative	0.72%	See Attached	12.24	24.48%	Alloc. Salary	36,713	17-7	6
7	Tom Winter	Shareholder	Administrative	0.72%	See Attached	10.57	17.62%	Alloc. Sal/Mgt	29,056	17-3, 17-7	7
8	Jeff Oravec	Shareholder	Administrative	0.48%	See Attached	8.90	22.25%	Alloc. Salary	22,092	17-7	8
9	Dennis Tossi	Shareholder	Administrative	3.12%	None	40.00	100.00%	Salary	125,175	17-1	9
10											10
11											11
12											12
13								TOTAL	\$ 326,360		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

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 999,524	10	\$ 7,576	\$	176,016	\$ 1,334	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 999,524	10	10,021		176,016	1,765	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 999,524	10	9,017		176,016	1,588	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 999,524	10	165,000	165,000	176,016	29,056	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 999,524	10	10,747		176,016	1,893	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 999,524	10	2,655		176,016	468	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 999,524	10	573,753	512,109	176,016	101,038	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 999,524	10	898		176,016	158	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 999,524	10	5,727		176,016	1,009	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 999,524	10	3,157		176,016	556	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 999,524	10	103,576		176,016	18,240	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 999,524	10	16,212		176,016	2,855	12
13	32	INTEREST	BOOK./ACCNT.INCOME 999,524	10	(5,190)		176,016	(914)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 999,524	10	23,306		176,016	4,104	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 999,524	10	19,888		176,016	3,502	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					10,008	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 946,343	\$ 677,109		\$ 176,660	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	621,946	10	\$ 14,269	\$ 138,383	\$ 3,175	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	621,946	10	77,891	51,158	138,383	17,331	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	621,946	10	9,520	138,383	2,118	3	
4	10	NURSING	PATIENT DAYS	621,946	10	184,832	184,832	138,383	41,125	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	621,946	10	33,100	138,383	7,365	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	621,946	10	104,417	138,383	23,233	6	
7	19	PROFESSIONAL FEES	PATIENT DAYS	621,946	10	2,646	138,383	589	7	
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	621,946	10	3,970	138,383	883	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	621,946	10	163,095	138,383	125,172	41,222	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	621,946	10	2,778	138,383	618	10	
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	621,946	10	24,542	138,383	5,461	11	
12	26	INSURANCE	PATIENT DAYS	621,946	10	5,228	138,383	1,163	12	
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	621,946	10	41,464	138,383	10,116	13	
14	30	DEPRECIATION	PATIENT DAYS	621,946	10	20,978	138,383	4,668	14	
15	32	INTEREST	PATIENT DAYS	621,946	10	4,752	138,383	1,057	15	
16	33	REAL ESTATE TAXES	PATIENT DAYS	621,946	10	44,103	138,383	9,813	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	621,946	10	20,518	138,383	4,565	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 758,103	\$ 465,579	\$ 174,502	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 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	DIETARY SALARIES	PATIENT DAYS	621,946	10	\$ 68,465	\$ 68,465	138,383	\$ 15,233	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	621,946	10	12,992		138,383	2,891	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	621,946	10	456,644	456,644	138,383	101,603	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	621,946	10	149,980		138,383	33,371	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	621,946	10	75,273		138,383	16,748	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	15,163	15,163	9	6,748	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	376		9	167	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,125		9	501	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	330		9	147	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	25,952		9	11,549	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,250		9	2,336	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	9,863	9,863	13	4,386	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	375		13	167	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	614		13	273	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	25,440		13	11,312	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	4,656		13	2,070	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 852,498	\$ 550,135		\$ 209,501	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 69,259	\$ 37,032	\$ 23,806	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,143	37,032	4,518	2
3									3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	126,720	10	76,680	576	349	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	126,720	10	14,551	576	66	5
6									6
7									7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	83,600	10	32,808	14,400	5,651	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	83,600	10	6,226	14,400	1,072	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					\$ 212,667	\$ 178,747	\$ 35,462	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 W. MAIN ST.  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 135,397	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				\$	\$		\$ 135,397	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 XCEL SUPPLY, LLC  
 Street Address 2201 W. MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

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	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	03	HOUSEKEEPING	Direct Allocation					689	2
3	04	LAUNDRY	Direct Allocation						3
4	06	REPAIRS & MAINTENANCE	Direct Allocation						4
5	10	NURSING	Direct Allocation					32,974	5
6	11	ACTIVITIES	Direct Allocation						6
7	12	SOCIAL SERVICE	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	24	SEMINARS & EDUCATION	Direct Allocation						11
12	39	ANCILLARY	Direct Allocation						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				\$	\$		\$	33,663

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ECM OWNERS COUNCIL  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60646  
 Phone Number ( 847)676-2026  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	HEALTH INSURANCE	DIRECT ALLOCATION	4	\$	\$		24,629	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				4,800	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				459	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				\$	\$		29,888	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Nomura		X	Mortgage	\$103,874.00	11/20/95	\$ 12,500,000	\$ 10,253,398	12/01/20	8.8800	\$ 937,469	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Lake Forest Bank		X	Working Capital		6/20/03		2,825,000			188,356	6								
7	Lake Forest Bank		X	Improvements				405,020			11,385	7								
8	See Supplemental Schedule										143	8								
9	<b>TOTAL Facility Related</b>				\$103,874.00		\$ 12,500,000	\$ 13,483,418			\$ 1,137,353	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(6,914)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(6,914)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 12,500,000	\$ 13,483,418			\$ 1,130,439	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
	<b>Working Capital</b>																			
8	<u>Alloc. - Preferred Bookkeeping</u>		X				\$	\$			\$ (914)	8								
9	<u>Alloc. - S.I.R. Management</u>		X								1,057	9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>										143	14								
	<b>B. Non-Facility Related*</b>																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>											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.)

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$ 447,000	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.)		\$ 458,990	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ 11,990	3																				
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 458,400	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 470,390	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2001	423,570	8																				
	2002	430,657	9																				
	2003	442,977	10																				
	2004	433,869	11																				
	2005	445,073	12																				
<table border="1"> <tr> <td colspan="2"></td> <td colspan="2"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>						<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
		<b>FOR BHF USE ONLY</b>																					
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
<p>Accrual = \$445,073 x 1.03 = \$458,400</p> <p>Allocation - Preferred Bookkeeping \$4,104</p> <p>Allocation - S.I.R. Management \$9,813</p>																							

NOTES:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- 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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Albany Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-19-121-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>445,072.59</u>	\$ <u>445,072.59</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>89,494.10</u>	\$ <u>13,055.66</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>534,566.69</u>	\$ <u>458,128.25</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X 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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**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)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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.

Facility Name & ID Number Albany Care

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	<u>Facility</u>	<u>24,573</u>		\$ <u>84,558</u>	1
2					2
3	<b>TOTALS</b>	<b>24,573</b>		\$ <b>84,558</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			1993	61,428		20	3,071	3,071	41,058	9
10	Various			1994	120,534		20	6,026	6,026	74,514	10
11	Various			1995	291,499		20	14,331	14,331	164,276	11
12	Various			1996	58,666		20	2,934	2,934	30,861	12
13	Various			1997	72,445		20	3,740	3,740	34,621	13
14	Various			1998	177,216		20	8,861	8,861	77,162	14
15	Various			1999	262,434		20	13,123	13,123	95,296	15
16	Various			2000	239,704		20	12,358	12,358	77,017	16
17	Various			2001	370,037		20	22,010	22,010	131,648	17
18	Various			2002	888,942		20	26,397	26,397	124,231	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		7,267,981	234,180		363,399	129,219	5,511,551	67
68		166,440	5,722		6,501	779	75,886	68
69			208,580			(208,580)		69
70		\$ 9,977,326	\$ 448,482		\$ 482,751	\$ 34,269	\$ 6,438,121	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,977,326	\$ 448,482		\$ 482,751	\$ 34,269	\$ 6,438,121	1
2	Elevator Work	2003	4,700		20	235	235	940	2
3	Garage Door	2003	1,955		20	196	196	782	3
4	Flooring	2003	54,803		20	2,740	2,740	10,276	4
5	Handrails	2003	7,291		20	1,458	1,458	5,468	5
6	Lobby Wallcovering	2003	5,219		20	261	261	826	6
7	Lobby Painting	2003	3,102		20	155	155	491	7
8	Hot Water Tank	2003	6,440		20	644	644	2,576	8
9	Kitchen Door	2003	4,839		20	968	968	3,145	9
10	Water Heater	2003	2,619		20	524	524	1,702	10
11	Elevator Car 2	2003	86,889		20	8,689	8,689	29,687	11
12	Elevator Car 1	2003	87,890		20	8,789	8,789	27,832	12
13	Lobby Renovation	2003	214,810		20	21,481	21,481	80,554	13
14	Drain Valve	2003	1,486		20	74	74	297	14
15	Pipe Repairs	2003	1,898		20	95	95	372	15
16	Wall Corner Guards	2003	550		20	28	28	101	16
17	Cubicle Track	2003	582		20	29	29	95	17
18	Elevator Generator	2003	4,166		20	208	208	798	18
19	Elevator Work	2004	7,000		20	350	350	1,050	19
20	Bathroom Work	2004	6,850		20	343	343	1,028	20
21	Fire Alarm System	2004	13,600		20	680	680	1,983	21
22	Phone System	2004	19,165		20	958	958	2,635	22
23	Hvac Work	2004	3,497		20	175	175	495	23
24	Boiler Tanks	2004	4,200		20	210	210	595	24
25	Elevator Car 3	2004	84,927		20	4,246	4,246	12,031	25
26	Water Heater	2004	2,779		20	139	139	382	26
27	Water Heater	2004	1,241		20	62	62	171	27
28	Elevator Work	2004	2,924		20	146	146	402	28
29	Elevator Work	2004	1,717		20	86	86	236	29
30	Stairway Rails	2004	7,485		20	374	374	936	30
31	Bathroom Work	2004	3,975		20	199	199	464	31
32	Roof	2004	70,300		20	3,515	3,515	8,202	32
33	Boiler Tank	2004	6,640		20	332	332	802	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,702,865	\$ 448,482		\$ 541,140	\$ 92,658	\$ 6,635,475	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Albany Care

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 10,702,865	\$ 448,482		\$ 541,140	\$ 92,658	\$ 6,635,475	1
2	Water Heater	2004	7,800		20	390	390	910	2
3	Roof	2004	13,525		20	676	676	1,522	3
4	Repair Collapsed Basement Wall	2004	1,200		20	60	60	170	4
5	Exhaust Fan	2004	1,269		20	63	63	164	5
6	Ramp Pass Door	2004	1,635		20	82	82	177	6
7	Walk-In-Freezer	2005	25,900		20	1,295	1,295	2,050	7
8	Masonry Work	2005	6,473		20	324	324	512	8
9	Bath Tub Liner	2005	3,750		20	188	188	297	9
10	Garage Doors	2005	3,452		20	173	173	273	10
11	Roof Top Fence	2005	1,718		20	86	86	129	11
12	Plumbing	2005	5,200		20	260	260	368	12
13	Freezer Electrical	2005	6,800		20	340	340	538	13
14	Hvac Work	2005	5,326		20	266	266	399	14
15	Down Spouts	2005	1,650		20	83	83	124	15
16	Sprinkler System	2005	9,975		20	499	499	665	16
17	Flooring - Tile	2005	11,114		20	556	556	880	17
18	Flooring - Carpet	2005	6,543		20	327	327	518	18
19	Flooring - Tile	2005	11,110		20	556	556	880	19
20	Flooring - Carpet	2005	13,079		20	654	654	1,035	20
21	Flooring - Tile	2005	29,267		20	1,463	1,463	2,317	21
22	Awning	2005	5,410		20	271	271	428	22
23	Flooring - Tile	2005	20,846		20	1,042	1,042	1,650	23
24	Elevator Walls	2005	11,662		20	583	583	923	24
25	Paint And Wallcover	2005	25,131		20	1,257	1,257	1,990	25
26	Shades & Blinds	2005	2,124		20	106	106	186	26
27	Install Elevator Signage	2005	2,665		20	133	133	178	27
28	Hvac Work	2005	1,156		20	58	58	116	28
29	Hvac Work	2005	1,341		20	67	67	78	29
30	Handrails	2006	3,201		20	320	320	320	30
31	Boiler Tube	2006	1,920		20	176	176	176	31
32	Nurse Call System	2006	6,324		20	237	237	237	32
33	Boiler	2006	10,400		20	217	217	217	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,961,831	\$ 448,482		\$ 553,948	\$ 105,466	\$ 6,655,902	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,961,831	\$ 448,482		\$ 553,948	\$ 105,466	\$ 6,655,902	1
2	Sewer Work	2006	5,300		20	110	110	110	2
3	Carpeting	2006	4,058		20	17	17	17	3
4	Fire Alarm System	2006	16,725		20	70	70	70	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
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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)		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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
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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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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13								13
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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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12K, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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
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18									18
19									19
20									20
21									21
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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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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
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16									16
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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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099	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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12P, Carried Forward	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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)	\$ 10,987,914	\$ 448,482		\$ 554,145	\$ 105,663	\$ 6,656,099		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

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	417		1991	1972	\$ 7,267,981	\$ 234,180		\$ 363,399	\$ 129,219	\$ 5,511,551	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 7,267,981	\$ 234,180		\$ 363,399	\$ 129,219	\$ 5,511,551	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

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 59,454	\$ 1,888	35	\$ 1,699	\$ (189)	\$ 22,932	4
5	SIR - PREF		1993	1993	24,866	790	35	710	(80)	9,591	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Preferred Bookkeeping - Allocation			1997	31,054	695	20	1,553	858	15,230	9
10	Preferred Bookkeeping - Allocation			1999	246	-	20	12	12	92	10
11	Preferred Bookkeeping - Allocation			2000	1,558	-	20	78	78	500	11
12											12
13	S.I.R. Properties - Preferred Bookkeeping - Allocation			2002	99	-	20	5	5	22	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation			1999	3,151	315	20	158	(157)	1,182	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation			1998	1,506	151	20	75	(76)	640	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation			1997	94	9	20	5	(4)	49	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation			1994	237	6	20	12	6	148	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation			1993	403	2	20	20	18	272	18
19											19
20	S.I.R. Properties - S.I.R. Management - Allocation			2002	236	-	20	12	12	53	20
21	S.I.R. Properties - S.I.R. Management - Allocation			1999	7,534	753	20	377	(376)	2,825	21
22	S.I.R. Properties - S.I.R. Management - Allocation			1998	3,600	360	20	180	(180)	1,530	22
23	S.I.R. Properties - S.I.R. Management - Allocation			1997	224	22	20	11	(11)	118	23
24	S.I.R. Properties - S.I.R. Management - Allocation			1994	566	15	20	28	13	354	24
25	S.I.R. Properties - S.I.R. Management - Allocation			1993	964	5	20	48	43	651	25
26											26
27	S.I.R. Management - Allocation			1993	25,535	711	20	1,266	555	17,724	27
28	S.I.R. Management - Allocation			1994	80	-	20	-		80	28
29	S.I.R. Management - Allocation			1995	584	-	20	29	29	333	29
30	S.I.R. Management - Allocation			1999	2,774	-	20	139	139	1,000	30
31	S.I.R. Management - Allocation			2000	1,675	-	20	84	84	560	31
32											32
33											33
34											34
35											35
36											36

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

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-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								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	166,440	\$	5,722	\$	6,501	\$	779	\$	75,886	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 # 0037762 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 714,210	\$ 1,537	\$ 65,312	\$ 63,775	10	\$ 587,905	71
72	Current Year Purchases	19,687	263	1,303	1,040	10	1,303	72
73	Fully Depreciated Assets	748,926				10	748,926	73
74								74
75	TOTALS	\$ 1,482,823	\$ 1,800	\$ 66,615	\$ 64,815		\$ 1,338,134	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,555,295	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 450,282	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 620,760	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 170,478	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,994,233	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	CIP	\$ 406,620	92
93			93
94			94
95		\$ 406,620	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	<b>TOTAL</b>				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 21,358

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	<u>Facility</u>	<u>2000 GMAC</u>	\$ <u>575.00</u>	\$ <u>7,033</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>575.00</u>	\$ <u>7,033</u>	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (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.)

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,769	\$ 13,211	1
2	Cash-Patient Deposits	55,640	55,640	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	4,316,170	4,774,570	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,969	41,969	6
7	Other Prepaid Expenses	6,280	6,280	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	162,436	162,436	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,586,264	\$ 5,054,106	10
<b>B. Long-Term Assets</b>				
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	2,575,135	2,633,613	15
16	Equipment, at Historical Cost	2,200,294	2,200,294	16
17	Accumulated Depreciation (book methods)	(2,185,140)	(5,728,228)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	406,620	423,407	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,996,909	\$ 6,881,625	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,583,173	\$ 11,935,731	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 197,925	\$ 197,926	26
27	Officer's Accounts Payable	5,702	5,702	27
28	Accounts Payable-Patient Deposits	59,336	59,336	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	401,368	401,368	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,196	478,596	31
32	Accrued Real Estate Taxes(Sch.IX-B)	458,400	458,400	32
33	Accrued Interest Payable	6,000	59,113	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	62,000	62,000	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	30,525	30,525	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,241,452	\$ 1,752,966	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	3,230,020	3,230,020	39
40	Mortgage Payable		10,253,398	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,230,020	\$ 13,483,418	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,471,472	\$ 15,236,384	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,111,701	\$ (3,300,653)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,583,173	\$ 11,935,731	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,496,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,496,672	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,615,829	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	(1,000,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 615,029</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 3,111,701</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,063,235	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,063,235	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	5,270	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,270	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,416	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,416	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,069,921	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,956,223	31
32	Health Care	3,629,999	32
33	General Administration	3,013,160	33
<b>B. Capital Expense</b>			
34	Ownership	2,626,402	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	228,308	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,454,092	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,615,829	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,615,829	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	1,734	1,954	\$ 99,429	\$ 50.88	1
2	Assistant Director of Nursing	1,728	1,971	49,278	25.00	2
3	Registered Nurses	3,133	3,331	86,397	25.94	3
4	Licensed Practical Nurses	38,248	40,763	913,407	22.41	4
5	CNAs & Orderlies	110,372	118,764	1,199,403	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,138	4,588	40,567	8.84	8
9	Activity Director	3,769	4,148	63,506	15.31	9
10	Activity Assistants	34,179	36,467	346,227	9.49	10
11	Social Service Workers	31,458	34,377	475,033	13.82	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,085	45,560	21.85	13
14	Head Cook	3,814	4,158	47,177	11.35	14
15	Cook Helpers/Assistants	22,298	24,388	223,661	9.17	15
16	Dishwashers					16
17	Maintenance Workers	5,633	5,940	75,266	12.67	17
18	Housekeepers	27,389	30,248	284,514	9.41	18
19	Laundry					19
20	Administrator	1,825	2,086	125,175	60.01	20
21	Assistant Administrator	2,805	3,118	65,519	21.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,022	29,978	335,183	11.18	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	4,978	5,600	86,179	15.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>326,420</b>	<b>353,964</b>	<b>\$ 4,561,481 *</b>	<b>\$ 12.89</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 73,511	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	82,572	10-03	38
39	Pharmacist Consultant	Monthly	7,128	10-03	39
40	Physical Therapy Consultant	1	60	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	49	10a-03	43
44	Activity Consultant	61	2,650	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	3,086	37,032	10a-03	47
48	<u>Psychiatric Consultant</u>	Monthly	3,600	10-03	48
49	<b>TOTAL (lines 35 - 48)</b>	<b>3,149</b>	<b>\$ 214,426</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 496	10-03	50
51	Licensed Practical Nurses	1,395	39,542	10-03	51
52	Certified Nurse Assistants/Aides				52
53	<b>TOTAL (lines 50 - 52)</b>	<b>1,403</b>	<b>\$ 40,038</b>		<b>53</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dennis Tossi	Administrator	3.12%	\$ 125,175	Workers' Compensation Insurance	\$ 49,381	IDPH License Fee	\$ 10,004	
Dan Allegretti	Asst. Admin.		45,050	Unemployment Compensation Insurance	65,751	Advertising: Employee Recruitment		
Heather Eisner	Admin In Training		20,470	FICA Taxes	341,636	Health Care Worker Background Check		
				Employee Health Insurance	209,936	(Indicate # of checks performed <u>153</u> )	1,530	
				Employee Meals	15,038	Patient Background Checks	400	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	28,433	
				401K Matching Contributions	10,083	Dues & Subscriptions	32,910	
				Other Employee Benefits	4,318	Advertising	4,143	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 190,695					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Dir of Admin Services-SIR Management			\$ 52,548				Out-of-State Travel	\$
Management Fees - SIR			659,025					
SIR Management - Council Fees			15,600				In-State Travel	
See Supplemental Schedule			42,625					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 769,798				Seminar Expense	3,067
(Attach a copy of any management service agreement)							Alloc. - Preferred Bookkeeping	158
							Alloc. - S.I.R. Management	618
C. Professional Services				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type		Amount			\$ 696,143		
Preferred Bookkeeping	Accounting		\$ 30,900					
FR&R	Accounting		13,245					
Preferred Bookkeeping	Bookkeeping Fees		145,116					
LTC Solutions	Computer Services		1,459					
ICS Solutions	Internet Services		53					
Personnel Planners	Unemployment Tax Consult.		1,087					
Preferred Bookkeeping	Computer Services		10,008					
Collections	Adj. Out On P. 5a		85					
SIR Management	Regulatory		33,780					
See Supplemental Schedule			2,804					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 238,537					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Albany Care

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Albany Care

**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. ICLTC - \$19253; IL Assoc. HF \$4587
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 178 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. \$ 228,308  
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. \$ 15,038 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT