

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 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: 11/1/1991

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
IRS Exemption Code _____	<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 01/01/07 to 12/31/07 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) <u>Steven N. Lavenda, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF				8	
9	SNF/PED				9	
10	ICF	<u>134,334</u>	<u>971</u>	<u>705</u>	<u>136,010</u>	10
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>134,334</u>	<u>971</u>	<u>705</u>	<u>136,010</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.36%

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

3,503 (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)

NoneF. 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 01/01/91 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: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	327,983	68,904	58,893	455,780		455,780	(26,648)	429,132		1
2	Food Purchase		461,361		461,361	(15,914)	445,447	(33)	445,414		2
3	Housekeeping	291,160	55,523		346,683		346,683	1,253	347,936		3
4	Laundry		36,446	27,970	64,416		64,416	(2,989)	61,427		4
5	Heat and Other Utilities			394,858	394,858		394,858	4,646	399,504		5
6	Maintenance	75,336	32,589	208,982	316,907		316,907	(43,161)	273,746		6
7	Other (specify):*							8,720	8,720		7
8	TOTAL General Services	694,479	654,823	690,703	2,040,005	(15,914)	2,024,091	(58,212)	1,965,879		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,570,668	71,904	179,921	2,822,493		2,822,493	(64,915)	2,757,578		10
10a	Therapy			37,102	37,102		37,102	(22,297)	14,805		10a
11	Activities	407,709	22,820	2,619	433,148		433,148		433,148		11
12	Social Services	517,896			517,896		517,896		517,896		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							9,914	9,914		15
16	TOTAL Health Care and Programs	3,496,273	94,724	223,242	3,814,239		3,814,239	(77,298)	3,736,941		16
	C. General Administration										
17	Administrative	186,103		771,720	957,823		957,823	(535,047)	422,776		17
18	Directors Fees										18
19	Professional Services			322,124	322,124	(3,262)	318,862	(237,725)	81,137		19
20	Dues, Fees, Subscriptions & Promotions			104,022	104,022		104,022	(12,085)	91,937		20
21	Clerical & General Office Expenses	303,089	98,473	125,955	527,517		527,517	(1,337)	526,180		21
22	Employee Benefits & Payroll Taxes			776,636	776,636	15,914	792,550	(30,894)	761,656		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,125	4,125		4,125	(1,844)	2,281		24
25	Other Admin. Staff Transportation			17,227	17,227		17,227	3,357	20,584		25
26	Insurance-Prop.Liab.Malpractice			341,233	341,233		341,233	957	342,190		26
27	Other (specify):*							73,739	73,739		27
28	TOTAL General Administration	489,192	98,473	2,463,042	3,050,707	12,652	3,063,359	(740,879)	2,322,480		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,679,944	848,020	3,376,987	8,904,951	(3,262)	8,901,689	(876,389)	8,025,300		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			219,832	219,832		219,832	390,188	610,020		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			148,436	148,436		148,436	872,304	1,020,740		32
33	Real Estate Taxes			474,401	474,401	3,262	477,663	15,485	493,148		33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)			34
35	Rent-Equipment & Vehicles			23,266	23,266		23,266	6,646	29,912		35
36	Other (specify):*										36
37	TOTAL Ownership			2,604,426	2,604,426	3,262	2,607,688	(453,868)	2,153,820		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			228,308	228,308		228,308		228,308		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			228,308	228,308		228,308		228,308		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,679,944	848,020	6,209,721	11,737,685		11,737,685	(1,330,257)	10,407,428		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: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	143,865	30		9
10	Interest and Other Investment Income	(23,114)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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	(6,250)	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	(3,217)	21		24
25	Fund Raising, Advertising and Promotional	(6,218)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,467)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(239,347)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,781)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(1,174,476)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,174,476)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,330,257)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Alhany Care ID# 0037762
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Prescription Drugs - VA	8 (8,950)	10	1
2 Purchased Services - VA	(2,258)	19	2
3 C/OP/I Dues	(4,548)	20	3
4 Bldg Co - Amortization	(47,762)	36	4
5 Bldg Co - Office Expense	6411	21	5
6 Bldg Co - Professional Fees	(37,179)	19	6
7 Bldg Co - Replacement Tax	(4,916)	21	7
8 Inty Duty Income	852	19	8
9 Rental Income	(1,545)	10	9
10 Cable TV	(691)	05	10
11 Collections	(251)	19	11
12 2008 Scanning Expense	881	24	12
13 Capitalized R&M	(13,343)	06	13
14 Insurance Expense	(1,378)	26	14
15 VA Expense - PPA	(2,158)	10	15
16 Legal Expense - PPA	(56,486)	19	16
17 Employee Benefits - PPA	(24,366)	22	17
18 Non Allowable Expenses	(30,000)	21	18
19 Capitalized R&M	(2,909)	04	19
20		20	20
21		21	21
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96		96	96
97		97	97
98		98	98
99		99	99
100		100	100
101 Total	(239,347)	101	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary					(26,648)							(26,648)	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping			1,326					(73)				1,253	3
4	Laundry	(2,989)											(2,989)	4
5	Heat and Other Utilities	(691)		2,101	3,236								4,646	5
6	Maintenance	(13,343)		1,844	(17,891)		(13,771)						(43,161)	6
7	Other (specify):*				2,066	3,176	3,478						8,720	7
8	TOTAL General Services	(17,056)		5,271	(12,589)	(23,472)	(10,293)		(73)				(58,212)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(14,955)			(46,442)				(3,518)				(64,915)	10
10a	Therapy						(22,297)						(22,297)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				6,970		2,944						9,914	15
16	TOTAL Health Care and Programs	(14,955)			(39,472)		(19,353)		(3,518)				(77,298)	16
	C. General Administration													
17	Administrative			31,373	(36,797)	(514,023)	(15,600)						(535,047)	17
18	Directors Fees													18
19	Professional Services	(93,836)	37,179	(181,747)	1,096	33,363	(33,780)						(237,725)	19
20	Fees, Subscriptions & Promotions	(17,013)		439	4,489								(12,085)	20
21	Clerical & General Office Expenses	(60,141)	5,457	103,781	15,213	545	(66,192)						(1,337)	21
22	Employee Benefits & Payroll Taxes	(24,306)					(6,600)			12			(30,894)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(85)		42	599		(2,400)						(1,844)	24
25	Other Admin. Staff Transportation			1,549	7,808		(6,000)						3,357	25
26	Insurance-Prop.Liab.Malpractice	(1,378)		578	1,185	572							957	26
27	Other (specify):*			19,937	12,623	41,179							73,739	27
28	TOTAL General Administration	(196,759)	42,636	(24,048)	6,216	(438,364)	(130,572)			12			(740,879)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(228,770)	42,636	(18,777)	(45,845)	(461,836)	(160,218)		(3,592)	12			(876,389)	29

STATE OF ILLINOIS

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	143,865	234,186	2,640	9,497								390,188	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23,114)	888,905	(102)	6,615								872,304	32
33	Real Estate Taxes			4,534	10,951								15,485	33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491)	34
35	Rent-Equipment & Vehicles			3,690	3,928	6,228	(7,200)						6,646	35
36	Other (specify):*	(47,762)	47,762											36
37	TOTAL Ownership	72,989	(567,638)	10,762	30,991	6,228	(7,200)						(453,868)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(155,781)	(525,002)	(8,015)	(14,854)	(455,607)	(167,418)		(3,592)	12			(1,330,257)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,738,491	Albany Care, LLC	100.00%	\$	\$ (1,738,491)	1
2	V	32 Interest Income	9,604	Albany Care, LLC	100.00%		(9,604)	2
3	V	36 Amortization		Albany Care, LLC	100.00%	47,762	47,762	3
4	V	30 Depreciation		Albany Care, LLC	100.00%	234,186	234,186	4
5	V	32 Mortgage Interest		Albany Care, LLC	100.00%	898,509	898,509	5
6	V	21 Office Expense		Albany Care, LLC	100.00%	541	541	6
7	V	19 Professional Fees		Albany Care, LLC	100.00%	37,179	37,179	7
8	V	33 Rent Taxes	474,401	Albany Care, LLC	100.00%	474,401		8
9	V	21 Replacement Tax		Albany Care, LLC	100.00%	4,916	4,916	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,222,496			\$ 1,697,494	\$ * (525,002)	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: 01/01/07Ending: 12/31/07

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%	\$ 1,326	\$ 1,326	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	2,101	2,101	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,844	1,844	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	31,373	31,373	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,494	1,494	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	439	439	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	103,781	103,781	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	42	42	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,549	1,549	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	578	578	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	19,937	19,937	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,640	2,640	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(102)	(102)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	4,534	4,534	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,690	3,690	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	183,241	PREFERRED BOOKKEEPING	100.00%		(183,241)	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		\$ 193,249			\$ 185,234	\$ * (8,015)	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: 01/01/07Ending: 12/31/07

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 3,236	\$ 3,236	15
16	V	6 REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	19,645	(17,891)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,066	2,066	17
18	V	10 NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	36,130	(46,442)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	6,970	6,970	19
20	V	17 ADMINISTRATIVE	60,888	S.I.R. MANAGEMENT, INC.	100.00%	24,091	(36,797)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,096	1,096	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	4,489	4,489	22
23	V	21 CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	57,753	15,213	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	599	599	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	7,808	7,808	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,185	1,185	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	12,623	12,623	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,497	9,497	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,615	6,615	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	10,951	10,951	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,928	3,928	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 223,536			\$ 208,682	\$ * (14,854)	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: 01/01/07Ending: 12/31/07

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%	\$ 15,892	\$ (26,648)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	3,176	3,176	16
17	V	17	ADMIN./LEGAL SALARIES	635,107	S.I.R. MANAGEMENT, INC.	100.00%	110,841	(524,266)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	33,363	33,363	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	22,344	22,344	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	7,131	7,131	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	409	409	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	264	264	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	9,543	9,543	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,616	3,616	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	3,112	3,112	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	136	136	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	308	308	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	9,292	9,292	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	2,612	2,612	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 677,647				\$ 222,040	\$ * (455,607)	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: 01/01/07Ending: 12/31/07

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%	14,735	\$	(22,297)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,944		2,944	16
17	V								17
18	V	6 REPAIRS AND MAINT.	25,776	S.I.R. MANAGEMENT, INC.	100.00%	17,405		(8,371)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,478		3,478	19
20	V								20
21	V								21
22	V								22
23	V								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		\$ 205,980			\$ 38,562	\$ *	(167,418)	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%	\$ 128,038	\$ 128,038	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	128,038	CCS EMPLOYEE BENEFIT GROUP	100.00%		(128,038)	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			\$ 128,038			\$ 128,038	\$ *	39

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

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/07Ending: 12/31/07

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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	911	Xcel Supply, LLC	100.00%	838	(73)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	43,625	Xcel Supply, LLC	100.00%	40,107	(3,518)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		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		\$ 44,536			\$ 40,944	\$ * (3,592)	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: 01/01/07

Ending: 12/31/07

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	\$ 27,900	ECM OWNERS COUNCIL	100.00%	\$ 28,058	\$ 158	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%	454	(146)	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		\$ 33,300			\$ 33,312	\$ *	12	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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	Owner	Administrative	7.31%	See Attached	7.48	18.70%	Alloc Sal/Mgt	\$ 37,131	17-3,17-7	1
2	Mike Giannini	Owner	Administrative	7.31%	See Attached	9.62	24.05%	Alloc Salary	3,112	17-7	2
3	Eric Rothner	Owner	Administrative	4.56%	See Attached	1.56	3.38%	Alloc Sal/Mgt	51,581	17-3, 17-7	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	11.12	22.24%	Alloc Salary	15,892	1-7	4
5	Patricia McDiarmid	Owner	Administrative	.480%	See Attached	11.12	22.24%	Alloc Salary	24,091	17-7	5
6	Louise Bergthold	Owner	Administrative	.719%	See Attached	12.23	22.24%	Alloc Salary	40,040	17-7	6
7	Tom Winter	Owner	Administrative	.719%	See Attached	10.46	17.43%	Alloc Salary	31,373	17-7	7
8	Jeff Oravec	Owner	Administrative	.480%	See Attached	8.90	22.25%	Alloc Salary	26,534	17-7	8
9	Kim Rudolph	Relative	Clerical	0%	See Attached	0.69	1.97%	Alloc Salary	606	22-7	9
10	Adam Vales	Relative	Clerical	1.20%	See Attached	0.79	1.98%	Alloc Salary	1,102	22-7	10
11	Dennis Tossi	Owner	Administrative	3.12%	See Attached	40.00	100.00%	Salary	126,062	17-1	11
12											12
13								TOTAL	\$ 357,524		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: 01/01/07 Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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 1,051,322	10	\$ 7,611	\$	183,241	\$ 1,326	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		183,241	2,101	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		183,241	1,844	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	183,241	31,373	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		183,241	1,494	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		183,241	439	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	183,241	103,781	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		183,241	42	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		183,241	1,549	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		183,241	578	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		183,241	19,937	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		183,241	2,640	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		183,241	(102)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		183,241	4,534	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		183,241	3,690	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				\$ 1,005,342	\$ 699,081		\$ 185,234	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	611,427	10	\$ 14,547	\$ 136,010	\$ 3,236	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	136,010	19,645	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289	136,010	2,066	3
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	136,010	36,130	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333	136,010	6,970	5
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	136,010	24,091	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925	136,010	1,096	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178	136,010	4,489	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	136,010	57,753	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693	136,010	599	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101	136,010	7,808	11
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328	136,010	1,185	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748	136,010	12,623	13
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694	136,010	9,497	14
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739	136,010	6,615	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229	136,010	10,951	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659	136,010	3,928	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 938,122	\$ 526,247	\$ 208,682	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 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

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	DIETARY SALARIES	PATIENT DAYS	611,427	10	\$ 71,444	\$ 71,444	136,010	\$ 15,892	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275		136,010	3,176	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	136,010	110,841	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980		136,010	33,363	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448		136,010	22,344	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	7	7,131	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10			7		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275		7	409	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824		7	264	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750		7	9,543	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272		7	3,616	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	10	3,112	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425		10	136	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959		10	308	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968		10	9,292	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144		10	2,612	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 947,979	\$ 601,659		\$ 222,040	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 42,868	\$ 42,868	37,032	\$ 14,735	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566		37,032	2,944	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	78,758	25,776	17,405	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737		25,776	3,478	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					\$ 145,929	\$ 121,626		\$ 38,562	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/07

Ending: 12/31/07

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 WEST MAIN STREET
 City / State / Zip Code EVANSTON, ILLINOIS 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		\$	\$		\$ 128,038	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				\$	\$		\$ 128,038	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 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	1	Dietary	Direct Allocation			\$		\$	1
2	3	Housekeeping	Direct Allocation					838	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					40,107	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	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					\$		\$	40,944

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$	\$		28,058	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				4,800	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				454	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				\$	\$		33,312	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/07 Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lake Forest Bank		X	Mortgage		12/11/07	\$ 10,000,000	\$ 10,000,000	12/10/08	7.2500	\$ 898,509	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Lake Forest Bank		X	Working Capital		6/20/03		1,600,000			105,155	6	
7	Lake Forest Bank		X	Improvements		3/10/06	750,000	522,972			43,281	7	
8	See Supplemental Schedule										6,513	8	
9	TOTAL Facility Related							\$ 10,750,000	\$ 12,122,972			\$ 1,053,458	9
	B. Non-Facility Related*												
10	Interest Income		X								(23,114)	10	
11	Interest Income - BuildingCoX	X									(9,604)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related							\$	\$			\$ (32,718)	14
15	TOTALS (line 9+line14)							\$ 10,750,000	\$ 12,122,972			\$ 1,020,740	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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:

01/01/07

Ending:

12/31/07

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8	Alloc. - Preferred Bookeeping		X				\$	\$			\$ (102)	8								
9	Alloc. - S.I.R. Management		X								6,615	9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.	11-19-121-019-0000	Long Term Care Property	\$ 452,801.01	\$ 452,801.01
2.	See Attached	See Attached	\$ 66,791.68	\$ 13,745.67
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 519,592.69	\$ 466,546.68

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Albany Care

0037762 Report Period Beginning:

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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	TOTALS	24,573		\$ 84,558	3

SEE ACCOUNTANTS' COMPILATION REPORT

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
		Improvement Type**									
9	Various		1993		61,428		20	3,071	3,071	44,129	9
10	Various		1994		120,534		20	6,026	6,026	80,543	10
11	Various		1995		291,499		20	14,331	14,331	178,607	11
12	Various		1996		58,666		20	2,934	2,934	33,793	12
13	Various		1997		72,445		20	3,643	3,643	38,263	13
14	Various		1998		177,216		20	8,861	8,861	86,023	14
15	Various		1999		262,434		20	13,123	13,123	108,415	15
16	Various		2000		239,704		20	12,358	12,358	89,367	16
17	Various		2001		370,037		20	22,010	22,010	153,656	17
18	Various		2002		888,942		20	25,816	25,816	150,044	18
19	Various		2003		489,239		20	46,574	46,574	212,517	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

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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
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		7,267,981	234,186		363,399	129,213	5,874,950	67
68		178,939	6,863		6,661	(202)	82,253	68
69			219,832			(219,832)		69
70		\$ 10,479,064	\$ 460,881		\$ 528,807	\$ 67,926	\$ 7,132,560	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12A, Carried Forward		\$ 10,479,064	\$ 460,881		\$ 528,807	\$ 67,926	\$ 7,132,560	1
2	Elevator Work	2004	7,000		20	350	350	1,400	2
3	Bathroom Work	2004	6,850		20	343	343	1,370	3
4	Fire Alarm System	2004	13,600		20	680	680	2,663	4
5	Phone System	2004	19,165		20	958	958	3,593	5
6	Hvac Work	2004	3,497		20	175	175	670	6
7	Boiler Tanks	2004	4,200		20	210	210	805	7
8	Elevator Car 3	2004	84,927		20	4,246	4,246	16,278	8
9	Water Heater	2004	2,779		20	139	139	521	9
10	Water Heater	2004	1,241		20	62	62	233	10
11	Elevator Work	2004	2,924		20	146	146	548	11
12	Elevator Work	2004	1,717		20	86	86	322	12
13	Stairway Rails	2004	7,485		20	374	374	1,310	13
14	Bathroom Work	2004	3,975		20	199	199	663	14
15	Roof	2004	70,300		20	3,515	3,515	11,717	15
16	Boiler Tank	2004	6,640		20	332	332	1,134	16
17	Water Heater	2004	7,800		20	390	390	1,300	17
18	Roof	2004	13,525		20	676	676	2,198	18
19	Repair Collapsed Basement Wall	2004	1,200		20	60	60	230	19
20	Exhaust Fan	2004	1,269		20	63	63	227	20
21	Mini-Blinds	2004			20				21
22	Mini-Blinds	2004			20				22
23	Ramp Pass Door	2004	1,635		20	82	82	259	23
24	Walk-In-Freezer	2005	25,900		20	1,295	1,295	3,345	24
25	Masonry Work	2005	6,473		20	324	324	836	25
26	Bath Tub Liner	2005	3,750		20	188	188	484	26
27	Garage Doors	2005	3,452		20	173	173	446	27
28	Roof Top Fence	2005	1,718		20	86	86	215	28
29	Plumbing	2005	5,200		20	260	260	628	29
30	Freezer Electrical	2005	6,800		20	340	340	878	30
31	Hvac Work	2005	5,326		20	266	266	666	31
32	Down Spouts	2005	1,650		20	83	83	206	32
33	Sprinkler System	2005	9,975		20	499	499	1,164	33
34	TOTAL (lines 1 thru 33)		\$ 10,811,037	\$ 460,881		\$ 545,407	\$ 84,526	\$ 7,188,869	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

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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 12B, Carried Forward		\$ 10,811,037	\$ 460,881		\$ 545,407	\$ 84,526	\$ 7,188,869	1
2	Flooring - Tile	2005	11,114		20	556	556	1,436	2
3	Flooring - Carpet	2005	6,543		20	327	327	845	3
4	Flooring - Tile	2005	11,110		20	556	556	1,435	4
5	Flooring - Carpet	2005	13,079		20	654	654	1,689	5
6	Flooring - Tile	2005	29,267		20	1,463	1,463	3,780	6
7	Awning	2005	5,410		20	271	271	699	7
8	Flooring - Tile	2005	20,846		20	1,042	1,042	2,693	8
9	Elevator Walls	2005	11,662		20	583	583	1,506	9
10	Paint And Wallcover	2005	25,131		20	1,257	1,257	3,246	10
11	Shades & Blinds	2005	2,124		20	106	106	292	11
12	Install Elevator Signage	2005	2,665		20	133	133	311	12
13	Hvac Work	2005	1,156		20	58	58	173	13
14	Hvac Work	2005	1,341		20	67	67	145	14
15	Handrails	2006	3,201		20	320	320	640	15
16	Boiler Tube	2006	1,920		20	192	192	368	16
17	Nurse Call System	2006	6,324		20	316	316	553	17
18	Boiler	2006	10,400		20	520	520	737	18
19	Sewer Work	2006	5,300		20	265	265	375	19
20	Carpeting	2006	4,058		20	203	203	220	20
21	Fire Alarm System	2006	16,725		20	836	836	906	21
22	Hot Water Heater	2007	9,650		20	362	362	362	22
23	Compressor	2007	2,351		20	49	49	49	23
24	Garage Door	2007	2,600		20	108	108	108	24
25	Shelving - Walk-In	2007	4,106		20	51	51	51	25
26	Hvac Thermostat	2007	1,058		20	26	26	26	26
27	Sprinkler System	2007	710,494		20	20,723	20,723	20,723	27
28	Sidewalk Work	2007	11,000		20	122	122	122	28
29	Boiler	2007	8,833		20	37	37	37	29
30	Elevator Hatch Door 4 Fl Repair	2007	3,162		20	79	79	79	30
31	Hvac	2007	2,877		20	84	84	84	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12D, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12E, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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
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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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12F, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Ending:

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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 12G, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12H, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12I, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12J, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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 12K, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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 12L, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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 12M, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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 12N, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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 12O, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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 12P, Carried Forward		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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)		\$ 11,756,544	\$ 460,881		\$ 576,773	\$ 115,892	\$ 7,232,559	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:

01/01/07

Ending:

12/31/07

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	\$ 234,186		\$ 363,399	\$ 129,213	\$ 5,874,950	4
5											5
6											6
7											7
8											8
Improvement Type**											
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:

01/01/07

Ending:

12/31/07

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	\$	234,186	\$	363,399	\$	129,213	\$	5,874,950	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	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 59,440	\$ 1,887	35	\$ 1,698	\$ (189)	\$ 24,625	4
5	SIR - PREF		1993	1993	24,612	781	35	703	(78)	10,196	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation		1997		30,736	688	20	1,537	849	16,611	9
10	Preferred Bookkeeping - Allocation		1999		244	-	20	12	12	104	10
11	Preferred Bookkeeping - Allocation		2000		1,542	-	20	77	77	572	11
12											12
13	SIR Management - Allocation		1993		25,529	711	20	1,265	554	18,985	13
14	SIR Management - Allocation		1994		80	-	20	-		80	14
15	SIR Management - Allocation		1995		583	-	20	29	29	362	15
16	SIR Management - Allocation		1999		2,773	-	20	139	139	1,139	16
17	SIR Management - Allocation		2000		1,674	-	20	84	84	644	17
18	SIR Management - Allocation		2007		11,701	1,104	20	114	(990)	114	18
19											19
20	SIR Properties - SIR Management		2007		1,041	52	20	52		52	20
21	SIR Properties - SIR Management		2002		235	-	20	12	12	65	21
22	SIR Properties - SIR Management		1999		7,532	753	20	377	(376)	3,201	22
23	SIR Properties - SIR Management		1998		3,599	360	20	180	(180)	1,710	23
24	SIR Properties - SIR Management		1997		224	11	20	11		129	24
25	SIR Properties - SIR Management		1994		566	15	20	28	13	382	25
26	SIR Properties - SIR Management		1993		964	5	20	48	43	699	26
27											27
28	SIR Properties - Preferred Bookkeeping		2007		431	22	20	22		22	28
29	SIR Properties - Preferred Bookkeeping		2002		98	-	20	5	5	27	29
30	SIR Properties - Preferred Bookkeeping		1999		3,119	312	20	156	(156)	1,325	30
31	SIR Properties - Preferred Bookkeeping		1998		1,490	149	20	75	(74)	708	31
32	SIR Properties - Preferred Bookkeeping		1997		93	5	20	5		53	32
33	SIR Properties - Preferred Bookkeeping		1994		234	6	20	12	6	158	33
34	SIR Properties - Preferred Bookkeeping		1993		399	2	20	20	18	290	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:

01/01/07

Ending:

12/31/07

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)	\$	178,939	\$	6,863	\$	6,661	\$	(202)	\$	82,253	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: 01/01/07 Ending: 12/31/07

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	\$ 544,026	\$ 1,219	\$ 30,851	\$ 29,632	10	\$ 426,903	71
72	Current Year Purchases	71,051	4,056	2,397	(1,659)	10	2,397	72
73	Fully Depreciated Assets	941,647				10	941,647	73
74								74
75	TOTALS	\$ 1,556,724	\$ 5,275	\$ 33,248	\$ 27,973		\$ 1,370,947	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)	\$ 13,397,826	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 466,156	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 610,021	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 143,865	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,603,506	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/07

Ending: 12/31/07

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 20,984

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>5,500</u>	17
18	<u>Alloc. From SIR Mgt.</u>			<u>3,429</u>	18
19					19
20					20
21	TOTAL		\$ <u>575.00</u>	\$ <u>8,929</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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					
					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): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,892	\$ 24,075	1
2	Cash-Patient Deposits	75,065	75,065	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,235,094	3,235,094	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,486	48,486	6
7	Other Prepaid Expenses	4,427	4,427	7
8	Accounts Receivable (owners or related parties)	8,529	8,529	8
9	Other(specify): <u>See Attached Schedule</u>	525	525	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,394,018	\$ 3,396,201	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,296,629	3,355,107	15
16	Equipment, at Historical Cost	2,250,878	2,250,878	16
17	Accumulated Depreciation (book methods)	(2,404,972)	(6,182,246)	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>	35,000	96,949	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,177,535	\$ 6,873,227	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,571,553	\$ 10,269,428	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,407	\$ 246,408	26
27	Officer's Accounts Payable	6,913	6,913	27
28	Accounts Payable-Patient Deposits	75,993	75,993	28
29	Short-Term Notes Payable	196,271	196,271	29
30	Accrued Salaries Payable	419,395	419,395	30
31	Accrued Taxes Payable (excluding real estate taxes)	68,571	68,571	31
32	Accrued Real Estate Taxes(Sch.IX-B)	480,000	480,000	32
33	Accrued Interest Payable	3,000	45,226	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	74,500	74,500	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>		35,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,571,050	\$ 1,648,277	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,926,701	1,926,701	39
40	Mortgage Payable		10,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,926,701	\$ 11,926,701	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,497,751	\$ 13,574,978	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,073,802	\$ (3,305,550)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,571,553	\$ 10,269,428	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,111,701	1
2	Restatements (describe):		2
3	<u>Rounding</u>	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,111,704	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,379,898	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	(1,417,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (37,902)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,073,802	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,092,872	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,092,872	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	23,114	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,114	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,597	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,597	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,117,583	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,040,005	31
32	Health Care	3,814,239	32
33	General Administration	3,050,707	33
B. Capital Expense			
34	Ownership	2,604,426	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	228,308	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,737,685	40
41	Income before Income Taxes (line 30 minus line 40)**	1,379,898	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,379,898	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:

01/01/07

Ending:

12/31/07

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	2,015	2,153	\$ 96,816	\$ 44.97	1
2	Assistant Director of Nursing	3,134	3,445	91,591	26.59	2
3	Registered Nurses	2,254	2,519	69,283	27.50	3
4	Licensed Practical Nurses	37,092	39,524	907,908	22.97	4
5	CNAs & Orderlies	110,376	119,823	1,286,140	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,544	4,051	62,290	15.38	9
10	Activity Assistants	33,054	36,010	345,419	9.59	10
11	Social Service Workers	36,676	39,624	517,896	13.07	11
12	Dietician					12
13	Food Service Supervisor	1,137	1,744	39,127	22.44	13
14	Head Cook	3,693	4,065	47,217	11.62	14
15	Cook Helpers/Assistants	23,800	25,472	241,639	9.49	15
16	Dishwashers					16
17	Maintenance Workers	5,473	5,807	75,336	12.97	17
18	Housekeepers	27,266	29,906	291,160	9.74	18
19	Laundry					19
20	Administrator	1,773	2,086	126,062	60.43	20
21	Assistant Administrator	2,474	2,929	60,041	20.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,984	29,518	303,089	10.27	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	5,878	6,427	118,930	18.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	326,623	355,103	\$ 4,679,944 *	\$ 13.18	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 58,893	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	5,680	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	70	10a-03	43
44	Activity Consultant	60	2,619	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	Monthly	37,032	10a-03	47
48	<u>Psychiatric Consultant</u>	Monthly	3,600	10-03	48
49	TOTAL (lines 35 - 48)	62	\$ 198,290		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	22	\$ 1,469	10-03	50
51	Licensed Practical Nurses	2,262	82,376	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,284	\$ 83,845		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC-\$19253; IL Assoc.HF\$5421; Alliance Liv\$23,520
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 172 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. \$ 15,914 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT