

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
Paid Preparer	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Cary N. Drazner, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 bedsN/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>152,622</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>152,622</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>137,110</u>	<u>542</u>	<u>1,257</u>	<u>138,909</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>137,110</u>	<u>542</u>	<u>1,257</u>	<u>138,909</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.02%

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

4,642 (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? YesG. 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 N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

* 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: 01/01/08 Ending: 12/31/08

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	356,355	68,513	62,426	487,294		487,294	(32,253)	455,041		1
2	Food Purchase		504,444		504,444	(16,982)	487,462	(20)	487,442		2
3	Housekeeping	292,713	63,912		356,625		356,625	(120)	356,505		3
4	Laundry		28,810	35,155	63,965		63,965	(88)	63,877		4
5	Heat and Other Utilities			414,789	414,789		414,789	4,116	418,905		5
6	Maintenance	81,831	29,024	205,618	316,473		316,473	(51,085)	265,388		6
7	Other (specify):*							5,519	5,519		7
8	TOTAL General Services	730,899	694,703	717,988	2,143,590	(16,982)	2,126,608	(73,931)	2,052,677		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,668,914	83,596	208,366	2,960,876		2,960,876	(78,402)	2,882,474		10
10a	Therapy			45,036	45,036		45,036	(38,387)	6,649		10a
11	Activities	431,956	18,088	1,148	451,192		451,192		451,192		11
12	Social Services	535,773			535,773		535,773		535,773		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,212	7,212		15
16	TOTAL Health Care and Programs	3,636,643	101,684	258,150	3,996,477		3,996,477	(109,577)	3,886,900		16
	C. General Administration										
17	Administrative	189,356		894,744	1,084,100		1,084,100	(635,430)	448,670		17
18	Directors Fees										18
19	Professional Services			295,736	295,736	(15,000)	280,736	(187,779)	92,957		19
20	Dues, Fees, Subscriptions & Promotions			115,514	115,514		115,514	(43,788)	71,726		20
21	Clerical & General Office Expenses	367,411	116,950	243,114	727,475		727,475	(46,777)	680,698		21
22	Employee Benefits & Payroll Taxes			796,393	796,393	16,982	813,375	(6,724)	806,651		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,049	7,049		7,049	(1,478)	5,571		24
25	Other Admin. Staff Transportation			19,690	19,690		19,690	11,810	31,500		25
26	Insurance-Prop.Liab.Malpractice			380,562	380,562		380,562	1,946	382,508		26
27	Other (specify):*							79,258	79,258		27
28	TOTAL General Administration	556,767	116,950	2,752,802	3,426,519	1,982	3,428,501	(828,962)	2,599,539		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,924,309	913,337	3,728,940	9,566,586	(15,000)	9,551,586	(1,012,470)	8,539,116		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			230,098	230,098		230,098	399,731	629,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,098	128,098		128,098	1,668,330	1,796,428			32
33	Real Estate Taxes					15,000	15,000	639,350	654,350			33
34	Rent-Facility & Grounds			2,999,337	2,999,337		2,999,337	(2,999,337)				34
35	Rent-Equipment & Vehicles			23,757	23,757		23,757	7,103	30,860			35
36	Other (specify):*											36
37	TOTAL Ownership			3,381,290	3,381,290	15,000	3,396,290	(284,823)	3,111,467			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			228,934	228,934		228,934		228,934			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			228,934	228,934		228,934		228,934			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,924,309	913,337	7,339,164	13,176,810		13,176,810	(1,297,292)	11,879,518			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: 01/01/08

Ending: 12/31/08

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	(846)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	104,204	30		9
10	Interest and Other Investment Income	(48,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(18,701)	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	(27,736)	21		24
25	Fund Raising, Advertising and Promotional	(4,594)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(22,629)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(429,848)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (448,607)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(848,685)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (848,685)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,297,292)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Albany Care

ID# 0037762
 Report Period Beginning: 01/01/08
 Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Jury Duty	\$ (17)	10	1
2	Prescription Durgs- VA	(17,518)	10	2
3	Purchased Services- VA	(2,224)	10	3
4	COPE Dues	(14,058)	20	4
5	Non-Allowable Seminar Expense	(190)	24	5
6	Rental Income	(449)	10	6
7	Amortization- Building Co.	(296,505)	36	7
8	Office Expense- Building Co.	(376)	21	8
9	Replacement Tax- Building Co.	(4,622)	21	9
10	Capitalized R&M	(22,831)	06	10
11	Non-Allowable Expense	(60,000)	21	11
12	Collections	(305)	21	12
13	Non-allowable Interest Expense	(745)	32	13
14	Alliance for Living PAC Dues	(10,008)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(429,848)		49

Albany Care

ID# 0037762

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/08

Ending:

12/31/08

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				(32,253)								(32,253)	1
2	Food Purchase	(20)											(20)	2
3	Housekeeping					(120)							(120)	3
4	Laundry					(88)							(88)	4
5	Heat and Other Utilities	(846)		4,962									4,116	5
6	Maintenance	(22,831)		(20,521)	(7,733)								(51,085)	6
7	Other (specify):*			1,727	3,792								5,519	7
8	TOTAL General Services	(23,697)		(13,832)	(36,194)	(208)							(73,931)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,208)		(69,084)	15,239	(4,349)							(78,402)	10
10a	Therapy				(38,387)								(38,387)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,531	3,681								7,212	15
16	TOTAL Health Care and Programs	(20,208)		(65,553)	(19,467)	(4,349)							(109,577)	16
	C. General Administration													
17	Administrative			(842,217)	206,787								(635,430)	17
18	Directors Fees													18
19	Professional Services			(216,962)	29,183								(187,779)	19
20	Fees, Subscriptions & Promotions	(47,361)		3,573									(43,788)	20
21	Clerical & General Office Expenses	(115,668)	4,998	120,270	(56,377)								(46,777)	21
22	Employee Benefits & Payroll Taxes				(6,600)			(124)					(6,724)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(190)		1,112	(2,400)								(1,478)	24
25	Other Admin. Staff Transportation			17,810	(6,000)								11,810	25
26	Insurance-Prop.Liab.Malpractice			1,946									1,946	26
27	Other (specify):*			34,778	44,480								79,258	27
28	TOTAL General Administration	(163,219)	4,998	(879,690)	209,073			(124)					(828,962)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(207,124)	4,998	(959,075)	153,412	(4,557)		(124)					(1,012,470)	29

STATE OF ILLINOIS

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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	104,204	270,635	24,892									399,731	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(49,183)	1,706,278	11,235									1,668,330	32
33	Real Estate Taxes		627,114	12,236									639,350	33
34	Rent-Facility & Grounds		(2,999,337)										(2,999,337)	34
35	Rent-Equipment & Vehicles			14,303	(7,200)								7,103	35
36	Other (specify):*	(296,505)	296,505											36
37	TOTAL Ownership	(241,484)	(98,805)	62,666	(7,200)								(284,823)	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)	(448,607)	(93,807)	(896,409)	146,212	(4,557)		(124)					(1,297,292)	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	\$ 2,999,337	Albany Care, LLC	100.00%	\$	\$ (2,999,337)	1
2	V	32 Interest Income	272,425	Albany Care, LLC			(272,425)	2
3	V	36 Amortization		Albany Care, LLC		296,505	296,505	3
4	V	30 Depreciation		Albany Care, LLC		270,635	270,635	4
5	V	21 Office Expense		Albany Care, LLC		376	376	5
6	V	32 Mortgage Interest		Albany Care, LLC		1,978,703	1,978,703	6
7	V	33 Real Estate Taxes		Albany Care, LLC		627,114	627,114	7
8	V	21 Replacement Tax		Albany Care, LLC		4,622	4,622	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,271,762			\$ 3,177,955	\$ * (93,807)	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: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 4,962	\$ 4,962	15
16	V	6 REPAIRS AND MAINT.	45,036	S.I.R. MANAGEMENT, INC.	100.00%	24,515	(20,521)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,727	1,727	17
18	V	10 NURSING	90,072	S.I.R. MANAGEMENT, INC.	100.00%	20,988	(69,084)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,531	3,531	19
20	V	17 ADMINISTRATIVE	842,217	S.I.R. MANAGEMENT, INC.	100.00%		(842,217)	20
21	V	19 PROFESSIONAL FEES	256,164	S.I.R. MANAGEMENT, INC.	100.00%	39,202	(216,962)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	3,573	3,573	22
23	V	21 CLERICAL & GENERAL	90,072	S.I.R. MANAGEMENT, INC.	100.00%	210,342	120,270	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,112	1,112	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	17,810	17,810	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,946	1,946	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	34,778	34,778	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	24,892	24,892	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	11,235	11,235	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	12,236	12,236	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	14,303	14,303	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,323,561			\$ 427,152	\$ * (896,409)	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: 01/01/08Ending: 12/31/08

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	\$ 45,036	S.I.R. MANAGEMENT, INC.	100.00%	\$ 12,783	\$ (32,253)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,090	2,090	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	15,239	15,239	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	2,417	2,417	18
19	V	17	ADMIN./LEGAL SALARIES	22,524	S.I.R. MANAGEMENT, INC.	100.00%	229,311	206,787	19
20	V	21	CLERICAL & OFFICE SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	9,815	9,815	20
21	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	29,183	29,183	21
22	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	44,480	44,480	22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	45,036	S.I.R. MANAGEMENT, INC.	100.00%	6,649	(38,387)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,264	1,264	25
26	V								26
27	V	6	MAINTENANCE SALARIES	10,488	S.I.R. MANAGEMENT, INC.	100.00%	8,155	(2,333)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,702	1,702	28
29	V								29
30	V	21	TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%		(66,192)	30
31	V	6	REPAIRS	5,400	S.I.R. MANAGEMENT, INC.	100.00%		(5,400)	31
32	V	35	EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%		(3,000)	32
33	V	35	AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%		(4,200)	33
34	V	25	TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%		(6,000)	34
35	V	24	SEMINARS	2,400	S.I.R. MANAGEMENT, INC.	100.00%		(2,400)	35
36	V	22	EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%		(6,600)	36
37	V								37
38	V								38
39	Total		\$ 216,876				\$ 363,088	\$ * 146,212	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	1,354	Xcel Supply, LLC	100.00%	1,234	(120)	16
17	V	4 Laundry	995	Xcel Supply, LLC	100.00%	907	(88)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	49,093	Xcel Supply, LLC	100.00%	44,745	(4,349)	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		\$ 51,443			\$ 46,886	\$ * (4,557)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 122,489	\$ 122,489	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	122,489	CCS Employee Benefits Group	100.00%		(122,489)	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			\$ 122,489			\$ 122,489	\$ *	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: 01/01/08

Ending: 12/31/08

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	\$ 33,500	ECM OWNERS COUNCIL	100.00%	\$ 33,531	\$ 31	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%	445	(155)	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		\$ 38,900			\$ 38,776	\$ *	(124)	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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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	5.15	12.88%	Alloc. Salary	\$ 33,455	17-7	1
2	Mike Giannini	Owner	Administrative	7.31%	See Attached	6.00	15.00%	Alloc. Salary	33,455	17-7	2
3	Eric Rothner	Owner	Administrative	4.56%	See Attached	1.20	2.60%	Alloc. Sal/ Mgt	48,867	17-3, 17-7	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	8.58	17.16%	Alloc. Salary	12,783	1-7	4
5	Patricia McDiarmid	Owner	Administrative	0.48%	See Attached	8.58	17.16%	Alloc. Salary	20,216	17-7	5
6	Louise Bergthold	Owner	Administrative	0.72%	See Attached	9.44	17.16%	Alloc. Salary	33,455	17-7	6
7	Tom Winter	Owner	Administrative	0.72%	See Attached	10.29	17.15%	Alloc. Salary	33,455	17-7	7
8	Jeff Oravec	Owner	Administrative	0.48%	See Attached	6.86	17.15%	Alloc. Salary	21,164	17-7	8
9	Kim Rudolph	Relative	Clerical	0%	See Attached	0.39	2.34%	Alloc. Salary	342	22-7	9
10	Adam Vales	Relative	Clerical	1.20%	See Attached	0.94	2.35%	Alloc. Salary	1,686	22-7	10
11	Dennis Tossi	Owner	Administrative	3.12%	See Attached	40.00	100.00%	Alloc. Salary	135,571	17-1	11
12	Sarah Barrish	Relative	Administrative	0%	See Attached	0.95	17.18%	Alloc. Salary	2,467	17-7	12
13								TOTAL	\$ 376,916		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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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	809,665	13	\$ 28,924	\$ 138,909	\$ 4,962	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	809,665	13	142,892	61,135	138,909	24,515	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	809,665	13	10,063		138,909	1,727	3
4	10	NURSING	PATIENT DAYS	809,665	13	122,335	122,335	138,909	20,988	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	809,665	13	20,583		138,909	3,531	5
6	17	ADMINISTRATIVE	PATIENT DAYS	809,665	13			138,909		6
7	19	PROFESSIONAL FEES	PATIENT DAYS	809,665	13	228,501	152,688	138,909	39,202	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	809,665	13	20,828		138,909	3,573	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	809,665	13	1,226,029	1,066,051	138,909	210,342	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	809,665	13	6,483		138,909	1,112	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	809,665	13	103,811		138,909	17,810	11
12	26	INSURANCE	PATIENT DAYS	809,665	13	11,341		138,909	1,946	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	809,665	13	202,715		138,909	34,778	13
14	30	DEPRECIATION	PATIENT DAYS	809,665	13	145,092		138,909	24,892	14
15	32	INTEREST	PATIENT DAYS	809,665	13	65,487		138,909	11,235	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	809,665	13	71,319		138,909	12,236	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	809,665	13	83,368		138,909	14,303	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,489,771	\$ 1,402,210		\$ 427,152	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	809,665	13	\$ 74,508	\$ 74,508	138,909	\$ 12,783	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	809,665	13	12,182		138,909	2,090	2
3	10	NURSING SALARIES	PATIENT DAYS	809,665	13	88,823	88,823	138,909	15,239	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	809,665	13	14,090		138,909	2,417	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	809,665	13	1,336,598	1,336,598	138,909	229,311	5
6	21	CLERICAL & OFFICE SALARIES	PATIENT DAYS	809,665	13	57,211	57,211	138,909	9,815	6
7	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	809,665	13	170,103		138,909	29,183	7
8	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	809,665	13	259,260		138,909	44,480	8
9										9
10	10A	DIRECTOR OF SPECIAL REHAB	SPECIAL REHAB INC.	268,263	13	39,604	39,604	45,036	6,649	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	268,263	13	7,528		45,036	1,264	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	153,288	9	119,187	119,187	10,488	8,155	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	153,288	9	24,879		10,488	1,702	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,203,973	\$ 1,715,931		\$ 363,088	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/08

Ending: 12/31/08

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					1,234	2
3	4	Laundry	Direct Allocation					907	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					44,745	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				\$	\$		\$ 46,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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		\$	\$		\$ 122,489	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				\$	\$		\$ 122,489	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$	\$		\$ 33,531	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				4,800	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				445	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				\$	\$		\$ 38,776	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762 Report Period Beginning: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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		3	4	5	6		7	8	9	10						
		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	Lake Forest Bank		X	Mortgage			\$	36,295,000			\$	1,978,703						
2	Lake Forest Bank		X	Sprinkler System				319,121				22,425						
3												3						
4												4						
5	See Supplemental Schedule											5						
Working Capital																		
6	Shareholder Loan	X						1,041,137				745						
7	Alloc. S.I.R. Management		X									11,235						
8	See Supplemental Schedule							2,700,000				104,928						
9	TOTAL Facility Related						\$	40,355,258			\$	2,118,036						
B. Non-Facility Related*																		
10	Interest Income		X									(48,438)						
11	Interest Income- Bldg Co.	X										(272,425)						
12			X	Shareholder Interest								(745)						
13	See Supplemental Schedule																	
14	TOTAL Non-Facility Related						\$				\$	(321,608)						
15	TOTALS (line 9+line14)						\$	40,355,258			\$	1,796,428						

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:

01/01/08

Ending:

12/31/08

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						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	Lake Forest Bank		X	Line of Credit			\$	\$ 2,700,000			\$ 104,928	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital							2,700,000			104,928	14						
B. Non-Facility Related*																		
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related											20						

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	480,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	558,950	2
3. Under or (over) accrual (line 2 minus line 1).		\$	78,950	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	560,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	15,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>81,681</u> For <u>2007</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	654,350	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>442,977</u>	<u>8</u>	
	2004	<u>433,869</u>	<u>9</u>	
	2005	<u>445,073</u>	<u>10</u>	
	2006	<u>452,801</u>	<u>11</u>	
	2007	<u>546,714</u>	<u>12</u>	
Accrual = \$ 558,950 x 1.00 = \$560,400 (Rounded)				
Allocation - S.I.R. Management \$12,236				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-19-121-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>546,714.18</u>	\$ <u>546,714.18</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>101,615.67</u>	\$ <u>12,539.95</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>648,329.85</u>	\$ <u>559,254.13</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
	TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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:

01/01/08 Ending:

12/31/08

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>	<u>1</u>
2					<u>2</u>
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	47,201	9
10	Various			1994	120,534		20	6,026	6,026	86,569	10
11	Various			1995	291,499		20	14,331	14,331	192,940	11
12	Various			1996	58,666		20	2,934	2,934	36,725	12
13	Various			1997	72,445		20	3,506	3,506	41,767	13
14	Various			1998	177,216		20	8,861	8,861	94,883	14
15	Various			1999	239,104		20	11,956	11,956	110,746	15
16	Various			2000	239,704		20	12,358	12,358	101,724	16
17	Various			2001	370,037		20	22,010	22,010	175,661	17
18	Various			2002	888,942		20	25,816	25,816	175,863	18
19	Various			2003	489,239		20	45,108	45,108	257,623	19
20	Various			2004	261,729		20	13,086	13,086	60,528	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning:

01/01/08

Ending:

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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
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		8,009,229	270,635		365,302	94,667	6,007,669	67
68		201,188	6,557		7,432	875	101,260	68
69			230,098			(230,098)		69
70		\$ 11,480,960	\$ 507,290		\$ 541,797	\$ 34,507	\$ 7,491,159	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

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Report Period Beginning:

01/01/08

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12/31/08

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		\$ 11,480,960	\$ 507,290		\$ 541,797	\$ 34,507	\$ 7,491,159	1
2	Walk-In-Freezer	2005	25,900		20	1,295	1,295	4,640	2
3	Masonry Work	2005	6,473		20	324	324	1,160	3
4	Bath Tub Liner	2005	3,750		20	188	188	672	4
5	Garage Doors	2005	3,452		20	173	173	618	5
6	Roof Top Fence	2005	1,718		20	86	86	301	6
7	Plumbing	2005	5,200		20	260	260	888	7
8	Freezer Electrical	2005	6,800		20	340	340	1,218	8
9	Hvac Work	2005	5,326		20	266	266	932	9
10	Down Spouts	2005	1,650		20	83	83	289	10
11	Sprinkler System	2005	9,975		20	499	499	1,663	11
12	Flooring - Tile	2005	11,114		20	556	556	1,991	12
13	Flooring - Carpet	2005	6,543		20	327	327	1,172	13
14	Flooring - Tile	2005	11,110		20	556	556	1,991	14
15	Flooring - Carpet	2005	13,079		20	654	654	2,343	15
16	Flooring - Tile	2005	29,267		20	1,463	1,463	5,244	16
17	Awning	2005	5,410		20	271	271	969	17
18	Flooring - Tile	2005	20,846		20	1,042	1,042	3,735	18
19	Elevator Walls	2005	11,662		20	583	583	2,089	19
20	Paint And Wallcover	2005	25,131		20	1,257	1,257	4,503	20
21	Shades & Blinds	2005	2,124		20	106	106	398	21
22	Install Elevator Signage	2005	2,665		20	133	133	444	22
23	Hvac Work	2005	1,156		20	58	58	231	23
24	Hvac Work	2005	1,341		20	67	67	212	24
25	Handrails	2006	3,201		20	320	320	960	25
26	Boiler Tube	2006	1,920		20	192	192	560	26
27	Nurse Call System	2006	6,324		20	316	316	870	27
28	Boiler	2006	10,400		20	520	520	1,257	28
29	Sewer Work	2006	5,300		20	265	265	640	29
30	Carpeting	2006	4,058		20	203	203	423	30
31	Fire Alarm System	2006	16,725		20	836	836	1,742	31
32	Hot Water Heater	2007	9,650		20	483	483	844	32
33	Garage Door	2007	2,600		20	260	260	368	33
34	TOTAL (lines 1 thru 33)		\$ 11,752,830	\$ 507,290		\$ 555,779	\$ 48,489	\$ 7,536,526	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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 12B, Carried Forward		\$ 11,752,830	\$ 507,290		\$ 555,779	\$ 48,489	\$ 7,536,526	1
2	Shelving - Walk-In	2007	4,106		20	205	205	257	2
3	Sprinkler System	2007	710,494		20	35,525	35,525	56,247	3
4	Sidewalk Work	2007	11,000		20	733	733	856	4
5	Boiler	2007	8,833		20	442	442	478	5
6	Elevator Hatch Door Repair	2007	3,162		20	158	158	237	6
7	Hvac	2007	2,877		20	144	144	228	7
8	Hvac Compressor	2008	4,200		20	210	210	210	8
9	A/C Units	2008	2,708		20	135	135	135	9
10	Bathroom Remodeling	2008	14,560		20	728	728	728	10
11	Pedestrian Door Frame	2008	2,958		20	148	148	148	11
12	Door Alarm/Security System	2008	2,605		20	130	130	130	12
13	Replaced Tiles, Mortar, & Shaver Pans In Shower Room	2008	2,800		20	140	140	140	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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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:

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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 12C, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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Report Period Beginning:

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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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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Report Period Beginning:

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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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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Report Period Beginning:

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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 12F, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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Report Period Beginning:

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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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Report Period Beginning:

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Ending:

12/31/08

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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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 12J, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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12/31/08

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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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 12L, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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18									18
19									19
20									20
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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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 12M, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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0037762

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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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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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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)		\$ 12,523,133	\$ 507,290		\$ 594,477	\$ 87,187	\$ 7,596,320	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:

01/01/08

Ending:

12/31/08

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	\$ 232,583	20	\$ 363,399	\$ 130,816	\$ 6,005,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Tile Flooring			2008	9,598	880	20	44	(836)	44	9
10	Bathroom Remodel			2008	403,200	18,120	20	906	(17,214)	906	10
11	Bathroom Remodel			2008	288,000	17,520	20	876	(16,644)	876	11
12	Bathtub Liners			2008	10,850	723	20	36	(687)	36	12
13	Bathtub Liners			2008	29,600	809	20	40	(769)	40	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:

01/01/08

Ending:

12/31/08

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)	\$	8,009,229	\$	270,635	\$	365,302	\$	94,667	\$	6,007,669	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 71,328	\$ 2,264	35	\$ 2,038	\$ (226)	\$ 31,588	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	SIR Properties - SIR Management			2007	1,249	243	20	62	(181)	125	11
12	SIR Properties - SIR Management			2002	283	-	20	14	14	92	12
13	SIR Properties - SIR Management			1999	9,038	904	20	452	(452)	4,293	13
14	SIR Properties - SIR Management			1998	4,319	-	20	216	216	2,268	14
15	SIR Properties - SIR Management			1997	269	-	20	13	13	168	15
16	SIR Properties - SIR Management			1994	679	17	20	34	17	492	16
17	SIR Properties - SIR Management			1993	1,157	6	20	58	52	897	17
18											18
19	SIR Management - Allocation			1993	19,689	548	20	976	428	15,618	19
20	SIR Management - Allocation			1994	61	-	20	-		61	20
21	SIR Management - Allocation			1995	450	-	20	22		302	21
22	SIR Management - Allocation			1997	30,254	677	20	1,513	836	17,864	22
23	SIR Management - Allocation			1999	25,709	-	20	119	119	24,429	23
24	SIR Management - Allocation			2000	2,809	-	20	140	140	1,200	24
25	SIR Management - Allocation			2007	9,024	-	20	451	451	539	25
26	SIR Management - Allocation			2008	24,870	1,898	20	1,324	(574)	1,324	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:

01/01/08

Ending:

12/31/08

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)	\$	201,188	\$	6,557	\$	7,432	\$	875	\$	101,260	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: 01/01/08 Ending: 12/31/08

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	\$ 492,702	\$ 15,792	\$ 32,870	\$ 17,078	10	\$ 350,506	71
72	Current Year Purchases	35,083	2,543	2,482	(61)	10	2,482	72
73	Fully Depreciated Assets	1,032,946				10	1,032,946	73
74								74
75	TOTALS	\$ 1,560,731	\$ 18,335	\$ 35,352	\$ 17,017		\$ 1,385,934	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)	\$ 14,168,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 525,625	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 629,829	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 104,204	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,982,254	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	Ward Door	\$ 422	92
93			93
94			94
95		\$ 422	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: 01/01/08

Ending: 12/31/08

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.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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: \$ 12,626

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>6,900</u>	17
18	<u>Allocation- SIR Management</u>			<u>11,334</u>	18
19					19
20					20
21	TOTAL		\$ <u>575.00</u>	\$ <u>18,234</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	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	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 4,226	\$ 359,704	1
2	Cash-Patient Deposits	118,174	118,174	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,830,342	4,852,968	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		9,575,000	5
6	Prepaid Insurance	61,654	61,654	6
7	Other Prepaid Expenses	4,754	4,754	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	577	577	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,019,727	\$ 14,972,831	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	3,300,829	4,042,077	15
16	Equipment, at Historical Cost	2,254,282	2,254,282	16
17	Accumulated Depreciation (book methods)	(2,635,070)	(6,624,501)	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>	741,670	188,066	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,661,711	\$ 7,212,463	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,681,438	\$ 22,185,294	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 381,118	\$ 381,118	26
27	Officer's Accounts Payable	61,381	61,381	27
28	Accounts Payable-Patient Deposits	120,905	120,905	28
29	Short-Term Notes Payable	1,041,137	1,041,137	29
30	Accrued Salaries Payable	525,883	525,883	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,648	31,648	31
32	Accrued Real Estate Taxes(Sch.IX-B)	329,000	560,400	32
33	Accrued Interest Payable	4,600	133,840	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	55,500	55,500	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,551,172	\$ 2,911,812	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,019,121	3,019,121	39
40	Mortgage Payable		36,295,000	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)	\$ 3,019,121	\$ 39,314,121	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,570,293	\$ 42,225,933	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,111,145	\$ (20,040,639)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,681,438	\$ 22,185,294	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,073,802	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,073,799	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,455,146	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)	\$ 37,346	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)	\$ 3,111,145	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 14,583,052	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,583,052	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***	48,438	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48,438	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	466	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 466	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,631,956	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,143,590	31
32	Health Care	3,996,477	32
33	General Administration	3,426,519	33
B. Capital Expense			
34	Ownership	3,381,290	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	228,934	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,176,810	40
41	Income before Income Taxes (line 30 minus line 40)**	1,455,146	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,455,146	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:

01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,935	2,095	\$ 101,451	\$ 48.43	1
2	Assistant Director of Nursing	3,747	4,145	110,573	26.68	2
3	Registered Nurses	3,492	3,703	102,788	27.76	3
4	Licensed Practical Nurses	36,550	40,425	925,411	22.89	4
5	CNAs & Orderlies	111,137	120,892	1,296,930	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,837	4,175	65,180	15.61	9
10	Activity Assistants	37,562	40,434	366,776	9.07	10
11	Social Service Workers	37,351	40,134	535,773	13.35	11
12	Dietician					12
13	Food Service Supervisor	1,727	1,881	46,107	24.51	13
14	Head Cook	3,502	4,062	49,249	12.12	14
15	Cook Helpers/Assistants	24,103	26,280	260,999	9.93	15
16	Dishwashers					16
17	Maintenance Workers	5,522	6,008	81,831	13.62	17
18	Housekeepers	27,752	30,375	292,713	9.64	18
19	Laundry					19
20	Administrator	1,833	2,091	135,571	64.84	20
21	Assistant Administrator	2,318	2,589	53,785	20.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,493	31,064	367,411	11.83	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	5,650	6,321	131,761	20.84	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	336,511	366,674	\$ 4,924,309 *	\$ 13.43	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	\$ 62,426	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,320	10-03	37
38	Nurse Consultant	Monthly	90,072	10-03	38
39	Pharmacist Consultant	Monthly	6,789	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,148	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	3,600	10a-03	47
48	Specialized Rehab	Monthly	45,036	10-03	48
49	TOTAL (lines 35 - 48)	26	\$ 216,991		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 566	10-03	50
51	Licensed Practical Nurses	2,583	103,019	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,592	\$ 103,585		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

0037762

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dennis Tossi	Administrator	3.12%	\$ 135,571	Workers' Compensation Insurance	\$ 86,648	IDPH License Fee	\$ 994	
Cynthia Schofield	Asst. Admin	0%	44,020	Unemployment Compensation Insurance	42,781	Advertising: Employee Recruitment	3,236	
Stefanie Thompson	Admin in Training	0%	9,765	FICA Taxes	370,625	Health Care Worker Background Check		
				Employee Health Insurance	271,881	(Indicate # of checks performed <u>59</u>)	597	
				Employee Meals	16,982	Patient Background Checks	156	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	35,875	
				401 Matching	9,464	Licenses & Permits	25,890	
				Employee Benefits Other	8,270	Alloc. S.I.R. Management	3,573	
						Advertising & Promotions	4,594	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 189,356					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Management Fees- SIR Management			\$ 752,148				Less: Public Relations Expense ()	
Council Fees- SIR Management			22,524				Non-allowable advertising (4,594)	
Dir of Admin Services- SIR Management			90,072				Yellow page advertising ()	
See Supplemental Schedule			30,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 894,744					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Unemployment Tax Csltg		\$ 1,798				Out-of-State Travel	\$
Frost, Ruttenberg, & Rothblatt	Accounting		17,465					
Pinnacle Consulting	Customer Satisfaction Survey		2,880					
SAS Architects & Planners	FSES Report		5				In-State Travel	
Patient Placement Systems	Computer Systems		300					
Amari & Locallo	Real Estate Appraisal		15,000					
LTC Solutions	Data Processing		1,500					
Kessler Orlean	Accounting		625				Seminar Expense	4,459
S.I.R. Management	Bookkeeping Fees		175,128				Alloc. S.I.R. Management	1,112
S.I.R. Management	Regulatory		45,036					
S.I.R. Management	Accounting		36,000					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense ()	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 295,737				(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 5,571	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Albany Care

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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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. See Attached
- (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. \$ 182 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. \$ 228,934
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. \$ 16,982 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT