

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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.

<p>I. IDPH License ID Number: <u>0037762</u></p> <p>Facility Name: <u>Albany Care Inc</u></p> <p>Address: <u>901 Maple</u> <u>Evanston</u> <u>60202</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 475-4000</u> Fax # <u>(847) 475-8316</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/01/91</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (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></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (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>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>417</u>	Intermediate (ICF)	<u>417</u>	<u>152,205</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>417</u>	TOTALS	<u>417</u>	<u>152,205</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>132,877</u>	<u>1,128</u>	<u>700</u>	<u>134,705</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>132,877</u>	<u>1,128</u>	<u>700</u>	<u>134,705</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.50%

D. How many bed-hold days during this year were paid by the Department? 1,459 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	398,943	58,478	68,088	525,509		525,509	(35,339)	490,170		1
2	Food Purchase		538,624		538,624	(18,688)	519,936	(45)	519,891		2
3	Housekeeping	317,506	75,187		392,693		392,693	(2,868)	389,825		3
4	Laundry		31,113	34,992	66,105		66,105		66,105		4
5	Heat and Other Utilities			327,642	327,642		327,642	1,381	329,023		5
6	Maintenance	68,778	53,590	262,042	384,410		384,410	(61,500)	322,910		6
7	Other (specify):*							15,521	15,521		7
8	TOTAL General Services	785,227	756,992	692,764	2,234,983	(18,688)	2,216,295	(82,850)	2,133,445		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,787,386	94,243	259,455	3,141,084		3,141,084	(82,401)	3,058,683		10
10a	Therapy			50,040	50,040		50,040	(30,528)	19,512		10a
11	Activities	461,902	26,267		488,169		488,169		488,169		11
12	Social Services	609,192		660	609,852		609,852		609,852		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							11,324	11,324		15
16	TOTAL Health Care and Programs	3,858,480	120,510	313,755	4,292,745		4,292,745	(101,605)	4,191,140		16
	C. General Administration										
17	Administrative	232,980		952,013	1,184,993		1,184,993	(682,139)	502,854		17
18	Directors Fees										18
19	Professional Services			313,643	313,643	(8,603)	305,040	(216,829)	88,211		19
20	Dues, Fees, Subscriptions & Promotions			84,264	84,264		84,264	(42,688)	41,576		20
21	Clerical & General Office Expenses	410,612	119,085	166,366	696,063		696,063	116,045	812,108		21
22	Employee Benefits & Payroll Taxes			874,090	874,090	18,688	892,778	(7,200)	885,578		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,334	5,334		5,334	(2,315)	3,019		24
25	Other Admin. Staff Transportation			24,695	24,695		24,695	12,662	37,357		25
26	Insurance-Prop.Liab.Malpractice			274,861	274,861		274,861	28,068	302,929		26
27	Other (specify):*							85,825	85,825		27
28	TOTAL General Administration	643,592	119,085	2,695,266	3,457,943	10,085	3,468,028	(708,571)	2,759,457		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,287,299	996,587	3,701,785	9,985,671	(8,603)	9,977,068	(893,026)	9,084,042		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 Inc

#0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			185,759	185,759		185,759	566,081	751,840			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,744	37,744		37,744	1,879,831	1,917,575			32
33	Real Estate Taxes			801	801	8,603	9,404	577,379	586,783			33
34	Rent-Facility & Grounds			3,748,000	3,748,000		3,748,000	(3,748,000)				34
35	Rent-Equipment & Vehicles			21,819	21,819		21,819	6,218	28,037			35
36	Other (specify):*							196,398	196,398			36
37	TOTAL Ownership			3,994,123	3,994,123	8,603	4,002,726	(522,093)	3,480,633			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,308	228,308		228,308		228,308			42
43	Other (specify):*			30,000	30,000		30,000	(30,000)				43
44	TOTAL Special Cost Centers			258,308	258,308		258,308	(30,000)	228,308			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,287,299	996,587	7,954,216	14,238,102		14,238,102	(1,445,119)	12,792,983			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 Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(3,825)	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	157,411	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(10,849)	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	(6,195)	21		24
25	Fund Raising, Advertising and Promotional	(1,979)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,375)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(176,317)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,175)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,400,944)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,400,944)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,445,119)		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 Inc

ID# 0037762
 Report Period Beginning: 01/01/11
 Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Rental Income - Misc. Income	\$ (1,320)	10	1
2	Jury Duty - Misc. Income	(69)	10	2
3	PTS Payphone - Misc. Income	(33)	10	3
4	Veteran - Drugs	(20,530)	10	4
5	Veteran - Purchased Services	(3,720)	10	5
6	Bank Charges	(5,895)	21	6
7	Shareholder Interest	(737)	32	7
8	Non-Allowable Expense	(30,000)	43	8
9	Collections	(2,550)	21	9
10	Alliance for Living - PAC Committee	(32,200)	20	10
11	Capitalized R&M	(25,502)	06	11
12	Non-Allowable Legal	(3,670)	19	12
13	Amortization - Bldg. Company	(10,984)	36	13
14	Repairs and Maintenance - Bldg Company	(29,086)	06	14
15	Filing Fees - Bldg Company	(350)	20	15
16	Replacement Tax - Bldg Company	(2,171)	21	16
17	Professional Fees - Bldg Company	(7,500)	19	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
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31				31
32				32
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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	(176,317)		49

Albany Care Inc

ID# 0037762

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
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86			37
87			38
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90			41
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93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(35,339)								(35,339)	1
2	Food Purchase	(45)											(45)	2
3	Housekeeping					(2,868)							(2,868)	3
4	Laundry													4
5	Heat and Other Utilities	(3,825)			5,206								1,381	5
6	Maintenance	(54,588)	29,086	(34,349)	(1,649)								(61,500)	6
7	Other (specify):*			1,699	13,822								15,521	7
8	TOTAL General Services	(58,458)	29,086	(32,650)	(17,960)	(2,868)							(82,850)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25,672)		(68,761)	15,292	(3,260)							(82,401)	10
10a	Therapy				(30,528)								(30,528)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,381	5,943								11,324	15
16	TOTAL Health Care and Programs	(25,672)		(63,380)	(9,293)	(3,260)							(101,605)	16
	C. General Administration													
17	Administrative			(838,401)	156,262								(682,139)	17
18	Directors Fees													18
19	Professional Services	(11,170)	7,500	(245,558)	32,399								(216,829)	19
20	Fees, Subscriptions & Promotions	(45,378)	350	2,340									(42,688)	20
21	Clerical & General Office Expenses	(19,186)	2,176	132,910	145								116,045	21
22	Employee Benefits & Payroll Taxes			(7,200)									(7,200)	22
23	Inservice Training & Education													23
24	Travel and Seminar			(2,315)									(2,315)	24
25	Other Admin. Staff Transportation			12,662									12,662	25
26	Insurance-Prop.Liab.Malpractice		24,914	2,908	246								28,068	26
27	Other (specify):*			50,542	35,283								85,825	27
28	TOTAL General Administration	(75,734)	34,940	(892,112)	224,335								(708,571)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,864)	64,026	(988,142)	197,082	(6,128)							(893,026)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	157,411	392,045		16,625								566,081	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(738)	1,883,836	(17,602)	14,335								1,879,831	32
33	Real Estate Taxes		564,301		13,078								577,379	33
34	Rent-Facility & Grounds		(3,748,000)										(3,748,000)	34
35	Rent-Equipment & Vehicles			6,218									6,218	35
36	Other (specify):*	(10,984)	207,382										196,398	36
37	TOTAL Ownership	145,689	(700,436)	(11,384)	44,038								(522,093)	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):*	(30,000)											(30,000)	43
44	TOTAL Special Cost Centers	(30,000)											(30,000)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(44,175)	(636,410)	(999,526)	241,120	(6,128)							(1,445,119)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 3,748,000	Albany Care, LLC		\$	\$(3,748,000)	1
2	V	36 Amortization		Albany Care, LLC		10,984	10,984	2
3	V	06 Repairs and Maintenance		Albany Care, LLC		29,086	29,086	3
4	V	30 Depreciation		Albany Care, LLC		392,045	392,045	4
5	V	20 Filing Fees		Albany Care, LLC		350	350	5
6	V	32 Mortgage Interest		Albany Care, LLC		1,885,418	1,885,418	6
7	V	36 MIP		Albany Care, LLC		196,398	196,398	7
8	V	21 Office Expense		Albany Care, LLC		5	5	8
9	V	19 Professional Fees		Albany Care, LLC		7,500	7,500	9
10	V	26 Property Insurance		Albany Care, LLC		24,914	24,914	10
11	V	33 Real Estate Taxes		Albany Care, LLC		564,301	564,301	11
12	V	32 Interest Income	1,582	Albany Care, LLC			(1,582)	12
13	V	21 Replacement Tax		Albany Care, LLC		2,171	2,171	13
14	Total		\$ 3,749,582			\$ 3,113,172	\$ * (636,410)	14

* 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	6 REPAIRS AND MAINT.	\$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	\$ 21,391	\$ (28,649)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,699	1,699
17	V	10 NURSING	100,080	S.I.R. MANAGEMENT, INC.	100.00%	31,319	(68,761)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	5,381	5,381
19	V	19 PROFESSIONAL FEES	271,188	S.I.R. MANAGEMENT, INC.	100.00%	25,630	(245,558)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,340	2,340
21	V	21 CLERICAL & GENERAL	100,080	S.I.R. MANAGEMENT, INC.	100.00%	105,377	5,297
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,397	1,397
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	19,262	19,262
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,908	2,908
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,240	9,240
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,602)	(17,602)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	14,018	14,018
28	V						
29	V	17 ADMINISTRATIVE	892,013	S.I.R. MANAGEMENT, INC.	100.00%	53,612	(838,401)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	3,850	
31	V	21 CLERICAL & GENERAL	70,380	S.I.R. MANAGEMENT, INC.	100.00%	197,993	127,613
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	41,302	41,302
33	V	6 REPAIRS AND MAINT.	5,700				(5,700)
34	V	22 EMPLOYEE BENEFITS	7,200				(7,200)
35	V	24 SEMINARS	3,712				(3,712)
36	V	25 TRAVEL	6,600				(6,600)
37	V	35 EQUIPMENT RENTAL	3,300				(3,300)
38	V	35 AUTO LEASE	4,500				(4,500)
39	Total		\$ 1,514,793			\$ 519,117	\$ * (999,526)

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

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/11Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	\$ 14,701	\$ (35,339)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,556	2,556	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	15,292	15,292	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	2,647	2,647	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	156,262	156,262	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	30,397	30,397	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	35,283	35,283	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	50,040	S.I.R. MANAGEMENT, INC.	100.00%	19,512	(30,528)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,296	3,296	25
26	V								26
27	V	6	MAINTENANCE SALARIES	59,984	S.I.R. MANAGEMENT, INC.	100.00%	56,205	(3,779)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	11,266	11,266	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	5,206	5,206	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	2,130	2,130	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	113	113	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	145	145	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	246	246	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	16,625	16,625	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	14,335	14,335	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	13,078	13,078	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	1,889	1,889	38
39	Total		\$ 160,064				\$ 401,184	\$ * 241,120	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	47,305	Xcel Supply, LLC	100.00%	44,437	(2,868)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	53,767	Xcel Supply, LLC	100.00%	50,507	(3,260)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	32 Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 101,072			\$ 94,944	\$ * (6,128)	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%	\$ 217,655	\$ 217,655	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	217,655	CCS Employee Benefits Group	100.00%		(217,655)	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		\$ 217,655			\$ 217,655	\$ *	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						\$	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.

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.

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.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES TRUST	1.199%	BRYN MAWR CARE INC.	CHICAGO	ALBANY CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ARI WOLFF	1.439%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRO TRUST	7.953%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	7.314%	ELMWOOD CARE, INC.	ELMWOOD PARK	EXTENDED CARE-OWNER'S CC	LINCOLNWOOD	MANAGEMENT CO.	4
5	CELESTE GIANNINI TRUST DTD 3/13/00	7.314%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	5
6	CHARLENE HILL -JEON	0.480%	GREENWOOD CARE, INC.	EVANSTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	CHERYL MAGENCE	1.439%	MAPLEWOOD CARE, INC.	ELGIN				7
8	DANIEL ROTHNER	0.719%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	DANIEL ROTHNER TRUST	1.199%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	DENNIS TOSSI	3.118%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	ELLIOTT AND RONNIE ROBINSON	2.386%	WILSON CARE, INC.	CHICAGO				11
12	ERIC ROTHNER	4.556%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	FREDA ROBINSON TRUST DTD 10/21/83	4.374%						13
14	GLENDA STRICKLAND	1.918%						14
15	HARVEY SCOTT	0.480%						15
16	JEFF ORAVEC	0.480%						16
17	JULIANA BARRISH TRUST DATED 1/26/93	7.314%						17
18	KATHRYN VALES TRUST	1.199%						18
19	LAURI WOLFF POLEN	1.439%						19
20	LOUISE BERGTHOLD	0.719%						20
21	MARILYN WOLFF REVOCABLE TRUST	4.357%						21
22	MELISSA ROTHNER	0.719%						22
23	MELISSA ROTHNER TRUST	1.199%						23
24	MICHAEL R GIANNINI TRUST DTD 3/13/00	7.314%						24
25	NOAH WOLFF REVOCABLE TRUST	4.357%						25
26	NORMAN L. MATTHEW	1.852%						26
27	PATRICIA MCDIARMID	0.480%						27
28	RACHEL ROTHNER	0.719%						28
29	RACHEL ROTHNER TRUST	1.199%						29
30	RANAN WOLFF	1.439%						30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SHELDON ROBINSON TRUST DTD 11/14/77	4.374%						1
2	SHELDON ROBINSON-LEVITT FAMILY TRUST	2.386%						2
3	STEVE AND BARBARA GELLER	2.386%						3
4	THE ESTATE OF NORMAN MATTHEW	6.101%						4
5	THOMAS WINTER	0.719%						5
6	TZIONA ZEFFREN	1.439%						6
7	WILLIAM ROTHNER	0.719%						7
8	WILLIAM ROTHNER TRUST	1.199%						8
9								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

Facility Name & ID Number

Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Eric Rothner	Owner	Administrative	4.56	See Attached	0.96	2.06%	Fee/Alloc.Sal	\$ 51,921	17-3;17-7	1	
2	Bryan Barrish	Owner	Administrative	7.31	See Attached	6.43	14.29%	Alloc. Salary	32,166	17-7	2	
3	Michael Giannini	Owner	Administrative	7.31	See Attached	5.63	14.08%	Fee/Alloc.Sal	56,858	17-3;17-7	3	
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	8.04	16.08%	Alloc. Salary	14,701	1-7	4	
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	8.04	16.08%	Alloc. Salary	19,258	17-7	5	
6	Kirsten Barrish	Relative	Clerical	N/A	See Attached	6.43	16.08%	Alloc. Salary	7,241	21-7	6	
7	Jeff Oravec	Owner	Administrative	0.48	See Attached	6.43	16.08%	Alloc. Salary	21,446	17-7	7	
8	Louise Bergthold	Owner	Administrative	0.72	See Attached	1.93	3.22%	Alloc. Salary	6,757	17-7	8	
9	Patricia McDiarmid	Owner	Administrative	0.48	See Attached	8.04	16.08%	Alloc. Salary	20,718	17-7	9	
10	Tom Winter	Owner	Administrative	0.72	See Attached	9.65	16.08%	Alloc. Salary	32,166	17-7	10	
11	Adam Vales	Owner	Clerical	1.20	See Attached	1.3	3.25%	Alloc. Salary	2,301	22-7	11	
12	See second page 7 for the detail of the additional owner and related compensation									147,875		12
13								TOTAL	\$ 413,408		13	

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	134,705	\$ 21,391	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		134,705	1,699	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	134,705	31,319	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		134,705	5,381	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	134,705	25,630	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		134,705	2,340	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	134,705	105,377	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		134,705	1,397	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		134,705	19,262	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		134,705	2,908	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		134,705	9,240	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		134,705	(17,602)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		134,705	14,018	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	134,705	53,612	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		134,705	3,850	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	134,705	197,993	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		134,705	41,302	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,626		\$ 519,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	134,705	\$ 14,701	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		134,705	2,556	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	134,705	15,292	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		134,705	2,647	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	134,705	156,262	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		134,705	30,397	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		134,705	35,283	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	50,040	19,512	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	315,820	13	20,802		50,040	3,296	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	59,984	56,205	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		59,984	11,266	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		2,071	5,206	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		2,071	2,130	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		2,071	113	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		2,071	145	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		2,071	246	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		2,071	16,625	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		2,071	14,335	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		2,071	13,078	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		2,071	1,889	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 401,184	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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					44,437	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					50,507	5
6	11	Activities	Direct Allocation						6
7	21	Office And Clerical	Direct Allocation						7
8	22	Employee Benefits	Direct Allocation						8
9	32	Fixed Assets-Depreciation	Direct Allocation						9
10	39	Ancillary	Direct Allocation						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				\$	\$		\$	94,944

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 217,655	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				\$	\$		\$ 217,655	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Inc

0037762 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Cambridge Capital		X	Mortgage			\$	\$ 39,060,646		\$ 1,885,418	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Shareholder's Loan	X								737	6								
7	Lake Forest Bank		X	Line of Credit				1,725,000		37,007	7								
8	See Supplemental Schedule									14,335	8								
9	TOTAL Facility Related					\$	\$ 40,785,646			\$ 1,937,497	9								
B. Non-Facility Related*																			
10			X	Shareholder Interest						(737)	10								
11	Interest Income		X							(1)	11								
12	Interest Income - Bldg. Co.	X								(1,581)	12								
13	See Supplemental Schedule									(17,602)	13								
14	TOTAL Non-Facility Related					\$	\$			\$ (19,921)	14								
15	TOTALS (line 9+line14)					\$	\$ 40,785,646			\$ 1,917,575	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 196,398 Line # 36

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

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 Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	Alloc. -SIR Management	X				\$	\$			\$	14,335	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital										14,335	14						
B. Non-Facility Related*																		
15	Alloc. -SIR Management	X				\$	\$			\$	(17,602)	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related										(17,602)	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.)

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.)

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 2010 report.		\$	<u>473,200</u>	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.)		\$	<u>519,380</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	46,180	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>532,000</u>	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.)		\$	<u>8,603</u>	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>801</u> For <u>2010</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.		\$	<u>586,783</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<u>452,801</u>		8	
	2007	<u>546,714</u>		9	
	2008	<u>567,685</u>		10	
	2009	<u>458,690</u>		11	
	2010	<u>506,302</u>		12	
Accrual = \$506,302 x 1.05 = \$532,000					
Alloc. -SIR Management: \$13,078					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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:

	1	2	3	4	
A. Land.	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	417	1991	1972	\$ 7,267,981	\$ 392,045	20	\$ 363,399	\$ (28,646)	\$ 6,769,064	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	117,446		20	5,872	5,872	106,831	9
10	Various		1994	120,519		20	6,026	6,026	104,633	10
11	Various		1995	293,974		20	14,454	14,454	237,910	11
12	Various		1996	58,666		20	2,933	2,933	45,525	12
13	Various		1997	72,445		20	3,505	3,505	52,282	13
14	Various		1998	177,216		20	8,861	8,861	121,465	14
15	Various		1999	239,104		20	11,955	11,955	146,610	15
16	Various		2000	239,704		20	11,615	11,615	137,987	16
17	Various		2001	370,037		20	20,839	20,839	240,516	17
18	Various		2002	887,772		20	25,816	25,816	253,310	18
19	Various		2003	489,239		20	43,624	43,624	388,494	19
20	Various		2004	261,729		20	13,086	13,086	99,787	20
21	Various		2005	211,692		20	10,585	10,585	69,458	21
22	Various		2006	47,928		20	2,652	2,652	14,409	22
23	Various		2007	752,722		20	37,949	37,949	173,364	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 Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,202,436			123,581	123,581	317,845	67
68		265,483	7,568		10,775	3,207	127,324	68
69			185,759			(185,759)		69
70		\$ 14,076,093	\$ 585,372		\$ 717,529	\$ 132,157	\$ 9,406,815	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 14,076,093	\$ 585,372		\$ 717,529	\$ 132,157	\$ 9,406,815	1
2	Hvac Compressor	2008	4,200		20	420	420	1,470	2
3	A/C Units	2008	2,708		20	135	135	496	3
4	Pedestrian Door Frame	2008	2,958		20	148	148	592	4
5	Door Alarm / Security System	2008	2,605		20	130	130	423	5
6	Replace Tiles, Mortar, & Shaver Pans In Shower Room	2008	2,800		20	140	140	432	6
7	Handrails	2009	11,410		20	571	571	1,189	7
8	Sewage And Pipeline	2009	8,300		20	415	415	1,245	8
9	Boiler Work	2009	3,427		20	171	171	485	9
10	Garage Door And Frame	2009	3,200		20	160	160	360	10
11	Boiler Repair	2010	4,295		20	215	215	233	11
12	Fire Rated Doors	2011	15,360		20	128	128	128	12
13	Condensate Tank Repair	2011	2,853		20	1,427	1,427	1,427	13
14	Cast Iron Pipe Repair	2011	2,875		20	144	144	144	14
15	Masonry Installations	2011	5,500		20	275	275	275	15
16	Ground Door Board Repair	2011	5,799		20	290	290	290	16
17	Replace Steam Traps	2011	8,475		20	424	424	424	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 14,162,858	\$ 585,372		\$ 722,722	\$ 137,350	\$ 9,416,427	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Tile Flooring	2008	9,598		20	480	480	1,920	9
10	Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2008	403,200		20	20,160	20,160	80,640	10
11	Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2008	288,000		20	14,400	14,400	57,600	11
12	Bathtub Liners	2008	10,850		20	543	543	2,171	12
13	Bathtub Liners	2008	29,600		20	1,480	1,480	5,920	13
14	Bathroom Remodel- Walls, Plumbing, Tiles, Fixtures	2009	124,950		20	9,128	9,128	27,384	14
15	Bathtub Liners	2009	14,125		20	706	706	2,118	15
16	Carpeting	2009	291,929		20	14,596	14,596	43,788	16
17	Roofing & Coating	2010	17,500		20	875	875	1,750	17
18	Driveway Concrete	2010	13,000		20	650	650	1,300	18
19	Tuckpointing & Chimney	2010	226,755		20	11,338	11,338	22,676	19
20	Fire Doors	2010	13,020		20	651	651	1,302	20
21	Building Improvements- Lighting 2nd Floor Laundry	2010	4,720		20	236	236	472	21
22	HVAC Upgrade	2010	200,420		20	10,021	10,021	20,042	22
23	Laundry Room- Drain Waste/ Vent and Gas Piping	2010	14,125		20	706	706	1,412	23
24	Lintel Replacement	2010	20,000		20	1,000	1,000	2,000	24
25	Admin Office- Pegasus Custom Furniture	2010	11,255		20	563	563	1,403	25
26	Boiler Work	2010	13,290		20	665	665	1,330	26
27	Lighting- Rooms	2010	82,400		20	4,120	4,120	8,240	27
28	Oxygen Rooms- Lighting, Exhaust fan, Duct work	2010	7,200		20	360	360	720	28
29	Window Treatments	2010	11,109		20	555	555	1,110	29
30	Window Treatments	2010	5,475		20	274	274	548	30
31	Window Treatments	2010	7,690		20	385	385	770	31
32	Building Improvements-Nurse Station Work	2010	12,000						32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Paint Basement Ceiling	2010	12,600		20	630	630	1,260	2
3	Tuckpointing	2010	3,000		20	150	150	300	3
4	Satellite System Wiring & Installation	2010	11,682		20	584	584	1,168	4
5	Duct Heater	2010	3,492		20	175	175	350	5
6	Kitchen Sink & Faucet	2011	2,882		20	9,589	9,589	9,589	6
7	Painting Basement Ceiling	2011	12,600		20	2,676	2,676	2,676	7
8	Carpeting	2011	3,931		20	190	190	190	8
9	Steam Traps	2011	8,810		20	135	135	135	9
10	Window Treatment - Admin	2011	2,738		20	137	137	137	10
11	Door Locks	2011	15,141		20	757	757	757	11
12	Ceiling Grid Replacement	2011	191,786		20	9,589	9,589	9,589	12
13	Television Wiring	2011	25,463		20	1,273	1,273	1,273	13
14	Smoke Tower Project	2011	69,599		20	3,480	3,480	3,480	14
15	Replace Window Air Conditioners	2011	3,801		20	190	190	190	15
16	Catch Basin, Drains in Bathrooms	2011	2,700		20	135	135	135	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 (12F & 12G lines 1 thru 33)		\$ 2,202,436	\$		\$ 123,581	\$ 123,581	\$ 317,845	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	S.I.R. Properties - S.I.R. Management	1993	72,785	2,311	35	2,080	(231)	36,392	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Properties - S.I.R. Management	2010	4,392		20	220	220	293	9
10	S.I.R. Properties - S.I.R. Management	2009	4,370	382	20	219	(163)	612	10
11	S.I.R. Properties - S.I.R. Management	2007	1,274	105	20	64	(41)	319	11
12	S.I.R. Properties - S.I.R. Management	2002	288		20	14	14	138	12
13	S.I.R. Properties - S.I.R. Management	1999	9,223		20	461	461	5,764	13
14	S.I.R. Properties - S.I.R. Management	1998	4,407		20	220	220	2,975	14
15	S.I.R. Properties - S.I.R. Management	1997	274		20	14	14	213	15
16	S.I.R. Properties - S.I.R. Management	1994	693	18	20	35	17	606	16
17	S.I.R. Properties - S.I.R. Management	1993	1,180	6	20	59	53	1,093	17
18									18
19	S.I.R. Management - Allocation	1993	18,453	514	20	915	401	17,381	19
20	S.I.R. Management - Allocation	1994	58		20			58	20
21	S.I.R. Management - Allocation	1995	422		20	21	21	346	21
22	S.I.R. Management - Allocation	1997	28,355	635	20	1,391	756	20,968	22
23	S.I.R. Management - Allocation	1999	2,229		20	112	112	1,365	23
24	S.I.R. Management - Allocation	1999	23,330		20			23,330	24
25	S.I.R. Management - Allocation	2000	2,632		20	132	132	1,519	25
26	S.I.R. Management - Allocation	2007	8,458	780	20	423	(357)	1,774	26
27	S.I.R. Management - Allocation	2008	23,309	2,227	20	1,469	(758)	5,648	27
28	S.I.R. Management - Allocation	2009	57,918	530	20	2,896	2,366	6,500	28
29	S.I.R. Management - Allocation	2011	1,433	60	20	30	(30)	30	29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 265,483	\$ 7,568		\$ 10,775	\$ 3,207	\$ 127,324	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 504,173	\$ 8,344	\$ 28,266	\$ 19,922	10	\$ 339,159	71
72	Current Year Purchases	179,957	18	18		10	18	72
73	Fully Depreciated Assets	1,098,533		36	36	10	1,098,533	73
74								74
75	TOTALS	\$ 1,782,663	\$ 8,362	\$ 28,320	\$ 19,958		\$ 1,437,710	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated - SIR Management	2011	\$ 5,652	\$ 696	\$ 800	\$ 104	5	\$ 1,119	76
77										77
78										78
79										79
80	TOTALS			\$ 5,652	\$ 696	\$ 800	\$ 104		\$ 1,119	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)	\$ 16,035,731	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 594,430	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 751,841	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 157,411	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,855,256	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 28,037 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* 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 Inc# 0037762Report Period Beginning: 01/01/11

Ending:

12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(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	\$ 45,799	\$ 464,982	1
2	Cash-Patient Deposits	50,977	50,977	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,735,372	2,735,372	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,395	48,470	6
7	Other Prepaid Expenses	4,214	4,214	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	26,283	26,283	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,909,040	\$ 3,330,298	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,353,887	5,595,835	15
16	Equipment, at Historical Cost	2,339,219	2,951,759	16
17	Accumulated Depreciation (book methods)	(3,239,280)	(8,269,599)	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>	25,463	1,132,348	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,479,289	\$ 8,762,882	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,388,329	\$ 12,093,180	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 230,504	\$ 255,967	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,003	51,003	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	458,518	458,518	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,690	16,690	31
32	Accrued Real Estate Taxes(Sch.IX-B)		532,000	32
33	Accrued Interest Payable		156,243	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,600	20,600	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	897	897	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 778,212	\$ 1,491,918	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,725,000	1,725,000	39
40	Mortgage Payable		39,060,646	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		23,799	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,725,000	\$ 40,809,445	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,503,212	\$ 42,301,363	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,885,117	\$ (30,208,183)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,388,329	\$ 12,093,180	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,051,765	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,051,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,612	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	(325,260)	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)	\$ (166,648)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,885,117	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/11Ending: 12/31/11

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	\$ 14,394,270	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,394,270	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***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	2,443	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,443	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,396,714	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,234,983	31
32	Health Care	4,292,745	32
33	General Administration	3,457,943	33
B. Capital Expense			
34	Ownership	3,994,123	34
C. Ancillary Expense			
35	Special Cost Centers	30,000	35
36	Provider Participation Fee	228,308	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,238,102	40
41	Income before Income Taxes (line 30 minus line 40)**	158,612	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 158,612	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 Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,969	2,086	\$ 111,467	\$ 53.44	1
2	Assistant Director of Nursing	3,759	4,200	129,675	30.88	2
3	Registered Nurses	1,415	1,480	48,597	32.84	3
4	Licensed Practical Nurses	35,676	39,275	922,060	23.48	4
5	CNAs & Orderlies	113,215	122,118	1,403,423	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,774	4,171	90,147	21.61	9
10	Activity Assistants	35,949	39,039	371,755	9.52	10
11	Social Service Workers	41,910	44,810	609,192	13.60	11
12	Dietician					12
13	Food Service Supervisor	1,809	2,086	58,618	28.10	13
14	Head Cook	3,625	4,067	53,804	13.23	14
15	Cook Helpers/Assistants	24,220	27,195	286,521	10.54	15
16	Dishwashers					16
17	Maintenance Workers	5,621	5,916	68,778	11.63	17
18	Housekeepers	28,055	30,342	317,506	10.46	18
19	Laundry					19
20	Administrator	1,860	2,086	146,608	70.28	20
21	Assistant Administrator	3,351	3,666	86,372	23.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	29,318	31,871	410,612	12.88	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	6,884	7,855	172,164	21.92	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	342,410	372,263	\$ 5,287,299 *	\$ 14.20	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	\$ 68,088	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	100,080	10-03	38
39	Pharmacist Consultant	Monthly	24,167	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	660	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	Monthly	50,040	10-03	47
48	<u>Psychiatric Consultant</u>	Monthly	4,500	10a-03	48
49	TOTAL (lines 35 - 48)		\$ 255,647		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	3,570	126,196	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,570	\$ 126,196		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

0037762

Report Period Beginning:

01/01/11

Ending:

12/31/11

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Alliance for Living - \$32,200
- (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. \$ 170 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 228,308
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,688 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT