



Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

**III. STATISTICAL DATA**

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

N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	<u>123,144</u>	<u>1,638</u>		<u>124,782</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>123,144</u>	<u>1,638</u>		<u>124,782</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.98%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 1/1/1991

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

YES  Date 1/1/1991 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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
	<b>A. General Services</b>										
1	Dietary	407,993	57,513	68,088	533,594		533,594	(36,164)	497,430		1
2	Food Purchase		544,596		544,596	(20,294)	524,302	(71)	524,231		2
3	Housekeeping	316,566	73,207		389,773		389,773		389,773		3
4	Laundry		18,777	36,106	54,883		54,883		54,883		4
5	Heat and Other Utilities			308,277	308,277		308,277	(16,956)	291,321		5
6	Maintenance	68,533	42,324	207,096	317,953		317,953	(22,752)	295,201		6
7	Other (specify):*							6,108	6,108		7
8	<b>TOTAL General Services</b>	793,092	736,417	619,567	2,149,076	(20,294)	2,128,782	(69,836)	2,058,946		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,714,105	57,104	183,814	2,955,023		2,955,023	(67,068)	2,887,955		10
10a	Therapy	57,273		50,040	107,313		107,313	(21,807)	85,506		10a
11	Activities	339,821	23,969		363,790		363,790		363,790		11
12	Social Services	443,459		7,200	450,659		450,659		450,659		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,072	8,072		15
16	<b>TOTAL Health Care and Programs</b>	3,554,658	81,073	244,654	3,880,385		3,880,385	(80,803)	3,799,582		16
	<b>C. General Administration</b>										
17	Administrative	202,615		802,966	1,005,581		1,005,581	(559,183)	446,398		17
18	Directors Fees										18
19	Professional Services			328,014	328,014	(50,666)	277,348	(187,106)	90,242		19
20	Dues, Fees, Subscriptions & Promotions			119,300	119,300		119,300	(82,169)	37,131		20
21	Clerical & General Office Expenses	422,017	101,808	193,654	717,479		717,479	106,101	823,580		21
22	Employee Benefits & Payroll Taxes			729,240	729,240	20,294	749,534	(7,200)	742,334		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,616	5,616		5,616	(724)	4,892		24
25	Other Admin. Staff Transportation			30,087	30,087		30,087	7,049	37,136		25
26	Insurance-Prop.Liab.Malpractice			261,076	261,076		261,076	32,961	294,037		26
27	Other (specify):*							76,483	76,483		27
28	<b>TOTAL General Administration</b>	624,632	101,808	2,469,953	3,196,393	(30,372)	3,166,021	(613,788)	2,552,233		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,972,382	919,298	3,334,174	9,225,854	(50,666)	9,175,188	(764,427)	8,410,761		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	<b>D. Ownership</b>											
30	Depreciation			164,240	164,240		164,240	385,706	549,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,547	10,547		10,547	1,456,596	1,467,143			32
33	Real Estate Taxes					50,666	50,666	569,673	620,339			33
34	Rent-Facility & Grounds			3,287,500	3,287,500		3,287,500	(3,287,500)				34
35	Rent-Equipment & Vehicles			15,772	15,772		15,772	8,116	23,888			35
36	Other (specify):*							191,386	191,386			36
37	<b>TOTAL Ownership</b>			3,478,059	3,478,059	50,666	3,528,725	(676,023)	2,852,702			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			569,323	569,323		569,323		569,323			42
43	Other (specify):*			60,000	60,000		60,000	(60,000)				43
44	<b>TOTAL Special Cost Centers</b>			629,323	629,323		629,323	(60,000)	569,323			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,972,382	919,298	7,441,556	13,333,236		13,333,236	(1,500,449)	11,832,787			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(20,950)	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	(41,176)	30		9
10	Interest and Other Investment Income	(759)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(71)	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	(3,850)	20		18
19	Entertainment				19
20	Contributions	(11,850)	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	(13,366)	21		24
25	Fund Raising, Advertising and Promotional	(5,217)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,059)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,142,227)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (3,243,525)		\$	30

<b>BHF USE ONLY</b>					
48		49	50	51	52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	1,743,076		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,743,076		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,500,449)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Albany Care

	ID#	<u>0037762</u>
Report Period Beginning:		<u>01/01/13</u>
Ending:		<u>12/31/13</u>

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Legal Fees- Collections	\$ (565)	21	1
2	Bank Fees	(6,441)	21	2
3	Alliance for Living- PAC Committee	(57,687)	20	3
4	Additional R&M	2,182	06	4
5	IDPH Penalty	(4,423)	20	5
6	Non- Allowable Legal	(2,234)	19	6
7	Non- Allowable Seminar	(112)	24	7
8	Non Allowable Admin. Expense	(60,000)	43	8
9	Capitalized R&M	(6,038)	06	9
10	Rental Income	(360)	21	10
11	Jury Duty Income	(34)	10	11
12				12
13	Building Co:			13
14	Amortization- Bldg. Company	(275,302)	36	14
15	Interest Exp- Repayment Penalty	(2,690,522)	21	15
16	Replacement Tax- Bldg. Company	(7,836)	21	16
17	Professional Fees- Bldg. Company	(16,003)	19	17
18	Licenses and Fees	(361)	20	18
19	Capitalized R&M - Building Company	(16,491)	06	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(3,142,227)	49

Albany Care

ID# 0037762

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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				(36,164)								(36,164)	1
2	Food Purchase	(71)											(71)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(20,950)			3,994								(16,956)	5
6	Maintenance	(20,347)	30,170	(31,526)	(1,049)								(22,752)	6
7	Other (specify):*			1,148	4,960								6,108	7
8	<b>TOTAL General Services</b>	<b>(41,368)</b>	<b>30,170</b>	<b>(30,378)</b>	<b>(28,260)</b>								<b>(69,836)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(34)		(82,207)	15,173								(67,068)	10
10a	Therapy				(21,807)								(21,807)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,338	5,734								8,072	15
16	<b>TOTAL Health Care and Programs</b>	<b>(34)</b>		<b>(79,869)</b>	<b>(899)</b>								<b>(80,803)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(721,592)	162,409								(559,183)	17
18	Directors Fees													18
19	Professional Services	(18,237)	16,003	(214,253)	29,381								(187,106)	19
20	Fees, Subscriptions & Promotions	(83,388)	361	858									(82,169)	20
21	Clerical & General Office Expenses	(2,723,149)	2,698,358	201,136	(70,244)								106,101	21
22	Employee Benefits & Payroll Taxes				(7,200)								(7,200)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(112)		(612)									(724)	24
25	Other Admin. Staff Transportation			7,049									7,049	25
26	Insurance-Prop.Liab.Malpractice		29,290	3,388	283								32,961	26
27	Other (specify):*			44,208	32,275								76,483	27
28	<b>TOTAL General Administration</b>	<b>(2,824,886)</b>	<b>2,744,012</b>	<b>(679,818)</b>	<b>146,904</b>								<b>(613,788)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(2,866,288)</b>	<b>2,774,182</b>	<b>(790,065)</b>	<b>117,745</b>								<b>(764,427)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(41,176)	414,833		12,049								385,706	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(759)	1,475,800	(30,987)	12,542								1,456,596	32
33	Real Estate Taxes		558,112		11,561								569,673	33
34	Rent-Facility & Grounds		(3,287,500)										(3,287,500)	34
35	Rent-Equipment & Vehicles			8,116									8,116	35
36	Other (specify):*	(275,302)	466,688										191,386	36
37	<b>TOTAL Ownership</b>	<b>(317,237)</b>	<b>(372,067)</b>	<b>(22,871)</b>	<b>36,152</b>								<b>(676,023)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,000)											(60,000)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(60,000)</b>											<b>(60,000)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(3,243,525)	2,402,115	(812,936)	153,897								(1,500,449)	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 Income	\$ 3,287,500	Albany, LLC	100.00%	\$	\$ (3,287,500)	1
2	V	32 Interest Income	247	Albany, LLC	100.00%	1,476,047	1,475,800	2
3	V	06 Repairs		Albany, LLC	100.00%	30,170	30,170	3
4	V	36 Amortization		Albany, LLC	100.00%	275,302	275,302	4
5	V	21 Int. Exp- Prepayment Penalty		Albany, LLC	100.00%	2,690,522	2,690,522	5
6	V	19 Professional Fees		Albany, LLC	100.00%	16,003	16,003	6
7	V	20 Liscense & Fees		Albany, LLC	100.00%	361	361	7
8	V	36 MIP Insurance Expense		Albany, LLC	100.00%	191,386	191,386	8
9	V	33 Real Estate Tax Expense- net		Albany, LLC	100.00%	558,112	558,112	9
10	V	26 Hazard Insurance Expense		Albany, LLC	100.00%	29,290	29,290	10
11	V	30 Depreciation		Albany, LLC	100.00%	414,833	414,833	11
12	V	21 Replacement Tax		Albany, LLC	100.00%	7,836	7,836	12
13	V							13
14	Total		\$ 3,287,747			\$ 5,689,862	\$ * 2,402,115	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	\$ 18,514	\$ (31,526)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,148	1,148
17	V	10 NURSING	100,080	S.I.R. MANAGEMENT, INC.	100.00%	17,873	(82,207)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,338	2,338
19	V	19 PROFESSIONAL FEES	251,172	S.I.R. MANAGEMENT, INC.	100.00%	29,192	(221,980)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	858	858
21	V	21 CLERICAL & GENERAL	100,080	S.I.R. MANAGEMENT, INC.	100.00%	102,160	2,080
22	V	24 EDUCATION & SEMINAR	2,400	S.I.R. MANAGEMENT, INC.	100.00%	1,788	(612)
23	V	25 OTHER ADMIN. STAFF TRANS.	11,100	S.I.R. MANAGEMENT, INC.	100.00%	18,149	7,049
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	3,388	3,388
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,360	14,360
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(30,987)	(30,987)
27	V	35 EQUIPMENT RENTAL	3,300	S.I.R. MANAGEMENT, INC.	100.00%	11,416	8,116
28	V						
29	V	17 ADMINISTRATIVE	772,966	S.I.R. MANAGEMENT, INC.	100.00%	51,374	(721,592)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	7,727	7,727
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	199,056	199,056
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	29,848	29,848
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,291,138			\$ 478,202	\$ * (812,936)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/13Ending: 12/31/13

## 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%	\$ 13,876	\$ (36,164)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,825	1,825	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	15,173	15,173	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,976	1,976	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	162,409	162,409	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	29,265	29,265	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	32,275	32,275	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	50,040	S.I.R. MANAGEMENT, INC.	100.00%	28,233	(21,807)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,758	3,758	25
26	V								26
27	V	6	MAINTENANCE SALARIES	17,894	S.I.R. MANAGEMENT, INC.	100.00%	21,054	3,160	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,135	3,135	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	3,994	3,994	30
31	V	6	REPAIRS AND MAINT.	5,700	S.I.R. MANAGEMENT, INC.	100.00%	1,491	(4,209)	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	116	116	32
33	V	21	CLERICAL & GENERAL	70,380	S.I.R. MANAGEMENT, INC.	100.00%	136	(70,244)	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	283	283	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	12,049	12,049	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	12,542	12,542	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	11,561	11,561	37
38	V	22	EMPLOYEE BENEFITS	7,200	S.I.R. MANAGEMENT, INC.	100.00%		(7,200)	38
39	Total		\$ 201,254				\$ 355,151	\$ * 153,897	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	39 Ancillary	\$ 493	Long Term Care Laboratory, LLC	100.00%	\$ 493	\$	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	<b>Total</b>		\$ 493			\$ 493	\$ *	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: 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	<b>Total</b>		\$			\$	\$ *	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: 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	<b>Total</b>		\$			\$	\$ *	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: 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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	ELLIOTT AND RONNIE ROBINSON	2.386091	APPLEWOOD REHABILITATION CENTER LLC	MATTESON	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	NOAH WOLFF REVOCABLE TRUST	4.357315	BRYN MAWR CARE INC	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO	2
3	MARILYN WOLFF RECOVERABLE TRUST	4.357314	COLUMBUS PARK NURSING & REHABILITATION CENTER INC	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	LAURI WOLFF POLEN	1.438848	DECATUR MANOR HEALTHCARE LLC	DECATUR	C.C.S VEBA	EVANSTON	HEALTH INSURANCE	4
5	RANAN WOLFF	1.438849	ELMWOOD CARE INC	ELMWOOD PARK	LONGTERM CARE LAB	ELK GROVE VILLAGE	LABORATORY	5
6	TZIONA ZEFRN	1.438850	FAIRVIEW NURSING PLAZA INC	ROCKFORD				6
7	ARI WOLFF	1.438848	GREENWOOD CARE INC	EVANSTON				7
8	CHERYL MAGENCE	1.438849	MAPLEWOOD CARE INC	ELGIN				8
9	ERIC ROTHNER	4.556355	NEIGHBORS REHABILITATION CENTER LLC	BYRON				9
10	MELISSA ROTHNER TRUST	1.199040	REGENCY REHABILITATION CENTER LLC	NILES				10
11	DANIEL ROTHNER TRUST	1.199041	ROCK ISLAND NURSING & REHAB CENTER LLC	ROCK ISLAND				11
12	WILLIAM ROTHNER TRUST	1.199041	WILSON CARE INC	CHICAGO				12
13	RACHEL ROTHNER TRUST	1.199041	WESLEY REHABILITATION CENTER	AUBURN, IN				13
14	ADAM VALES TRUST	1.199041						14
15	KATHRYN VALES TRUST	1.199041						15
16	DENNIS TOSSI	3.117505						16
17	JEFF ORAVEC	.479617						17
18	CHARLENE HILL- JEON	.4796176						18
19	PATRICIA MCDIARMID	.4796177						19
20	GLENDA STRICKLAND	1.918464						20
21	STEVE AND BARBARA GELLER	2.386092						21
22	HARVEY SCOTT	.479616						22
23	LOUISE BERGTHOLD	.719425						23
24	THOMAS WINTER	.719425						24
25	MICHAEL R GIANNIN TRUST DTD 3/13/00	7.314148						25
26	CELESTE GIANNINI TRUST DTD 3/13/00	7.314149						26
27	THE ESTATE OF NORMAN MATTHEW	7.9532						27
28	SHELDON ROBINSON TRUST DTD 11/14/77	4.374100						28
29	FREDA ROBINSON TRUST DTD 10/21/83	4.374101						29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	JULIANA BARRISH TRUST DATED 1/26/93	7.314149						1
2	BRYAN BARRISH TRUST DTD 09/01/2004	7.3141148						2
3	SHELDON ROBINSON- LEVITT FAMILY TRUST	2.386091						3
4	MELISSA ROTHNER	.719425						4
5	DANIEL ROTHNER	.719424						5
6	WILLIAM ROTHNER	.719424						6
7	RACHEL ROTHNER	.719425						7
8	EDWARD MATTHEW	2.6511						8
9	KENNETH MATTHEW	2.651080						9
10	SAMUEL MATTHEW/ BRO TRUST	1.3255						10
11	HARRISON MATTHEW/ BRO TRUST	1.3255						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Bryan Barrish	Relative	Administrative	N/A	See Attached	6.06	13.47%	Alloc. Salary	\$ 30,295	17-7	1
2	Kirsten Barrish	Relative	Clerical	N/A	See Attached	7.57	15%	Alloc. Salary	7,633	21-7	2
3	Sarah Barrish	Relative	Administrative	N/A	See Attached	6.82	15%	Alloc. Salary	14,417	17-7	3
4	Louise Bergthold	Owner	Administrative	.719425	See Attached	9.09	15%	Alloc. Salary	30,295	17-7	4
5	Michael Giannini	Relative	Administrative	N/A	See Attached	5.3	13%	Fee/Alloc.Sal	55,348	17-3;17-7	5
6	Nenita Guzman	Relative	Dietary	N/A	See Attached	7.57	15%	Alloc. Salary	13,876	1-7	6
7	Patricia McDiarmid	Owner	Administrative	.4796177	See Attached	7.57	15%	Alloc. Salary	20,785	17-7	7
8	Jeff Oravec	Owner	Administrative	.479617	See Attached	6.06	15%	Alloc. Salary	21,079	17-7	8
9	Dennis Tossi	Owner	Administrative	3.117505	See Attached	40	100%	Salary	147,769	17-1	9
10	See Supplemental Schedule								30,774		10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 372,271		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	823,778	14	\$ 122,226	\$ 54,106	124,782	\$ 18,514	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581	124,782	124,782	1,148	2
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	124,782	17,873	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435	124,782	124,782	2,338	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	124,782	29,192	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665	124,782	124,782	858	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	124,782	102,160	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805	124,782	124,782	1,788	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815	124,782	124,782	18,149	9
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368	124,782	124,782	3,388	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799	124,782	124,782	14,360	11
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)	124,782	124,782	(30,987)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364	124,782	124,782	11,416	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	124,782	51,374	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011	124,782	124,782	7,727	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	124,782	199,056	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046	124,782	124,782	29,848	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,156,964	\$ 2,409,562		\$ 478,202	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	823,778	14	\$ 91,605	\$ 91,605	124,782	\$ 13,876	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049		124,782	1,825	2
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	124,782	15,173	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047		124,782	1,976	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	124,782	162,409	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200		124,782	29,265	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069		124,782	32,275	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	50,040	28,233	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	293,544	14	22,047		50,040	3,758	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	17,894	21,054	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242		17,894	3,135	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365		1,951	3,994	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845		1,951	1,491	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768		1,951	116	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896		1,951	136	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870		1,951	283	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536		1,951	12,049	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793		1,951	12,542	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319		1,951	11,561	23
24										24
25	TOTALS					\$ 2,672,494	\$ 1,874,447		\$ 355,151	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Long Term Care Laboratory, LLC  
 Street Address 2458 Elmhurst Road  
 City / State / Zip Code Elk Grove Village, IL 60007  
 Phone Number ( 630)422-7800  
 Fax Number ( 847)422-1360

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	39	Ancillary	Direct Allocation		\$	\$		\$ 493	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				\$	\$		\$ 493	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Cambridge Capital		X	Mortgage			\$	\$ 37,988,441			\$ 1,476,047	1				
2												2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6	HP Bank		X	Line of Credit				170,000			10,547	6				
7	Alloc. SIR Management	X									12,542	7				
8												8				
9	<b>TOTAL Facility Related</b>						\$	\$ 38,158,441			\$ 1,499,136	9				
<b>B. Non-Facility Related*</b>																
10	Interest Income		X								(759)	10				
11	Interest Income- BLDG Co	X									(247)	11				
12	Alloc. -SIR Management	X									(30,987)	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (31,993)	14				
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 38,158,441			\$ 1,467,143	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ 191,386     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

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

\* 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.)



## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0037762  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-19-121-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>533,111.83</u>	\$ <u>533,111.83</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>106,516.99</u>	\$ <u>12,636.95</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>639,628.82</u></u>	\$ <u><u>545,748.78</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Albany Care

# 0037762 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 211,753 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 7

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>24,573</u>		\$ <u>84,558</u>	1
2					2
3	<b>TOTALS</b>	<b>24,573</b>		\$ <b>84,558</b>	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	\$ 7,267,391	\$ 230,686	35	\$ 134,928	\$ (95,758)	\$ 7,267,391	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1993	61,428		20	1,935	1,935	61,421	9
10	Various		1994	120,534		20	5,992	5,992	116,665	10
11	Various		1995	291,499		20	14,331	14,331	264,591	11
12	Various		1996	58,666		20	2,933	2,933	51,392	12
13	Various		1997	72,445		20	3,505	3,505	59,292	13
14	Various		1998	177,216		20	8,861	8,861	139,187	14
15	Various		1999	239,104		20	11,955	11,955	170,520	15
16	Various		2000	239,704		20	11,615	11,615	161,217	16
17	Various		2001	370,037		20	14,996	14,996	270,508	17
18	Various		2002	887,772		20	21,951	21,951	296,532	18
19	Various		2003	489,239		20	21,588	21,588	453,706	19
20	Various		2004	261,729		20	13,086	13,086	125,960	20
21	Various		2005	211,692		20	10,585	10,585	90,627	21
22	Various		2006	47,928		20	2,652	2,652	19,714	22
23	Various		2007	752,722		20	37,949	37,949	249,263	23
24	Various		2008	15,271		20	974	974	5,360	24
25	Various		2009	26,337		20	1,317	1,317	5,913	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

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		2,407,343	122,439		124,984	2,545	553,389	67
68		297,862	7,632		10,720	3,088	147,307	68
69			164,240			(164,240)		69
70		\$ 14,295,919	\$ 524,997		\$ 456,857	\$ (68,140)	\$ 10,509,955	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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,295,919	\$ 524,997		\$ 456,857	\$ (68,140)	\$ 10,509,955	1
2	Boiler Repair	2010	4,295		20	215	215	662	2
3	Fire Rated Doors	2011	15,360		20	768	768	1,664	3
4	Condensate Tank Repair	2011	2,853		20	285	285	594	4
5	Cast Iron Pipe Repair	2011	2,875		20	288	288	599	5
6	Masonry Installations	2011	5,500		20	550	550	1,146	6
7	Ground Door Board Repair	2011	5,799		20	580	580	1,208	7
8	Replaced Steam Traps	2011	8,475		20	847	847	1,766	8
9	Replace Compressor 1&2 On Dining Rm Unit	2012	3,572		20	357	357	536	9
10	Drain Repairs	2012	2,600		20	260	260	303	10
11	Interior Lighting	2013	21,310		20	1,066	1,066	1,066	11
12	Elevator Work	2013	6,832		20	85	85	85	12
13	Water Heater	2013	6,131		20	26	26	26	13
14	Sewer And Drain	2013	2,800		20	140	140	140	14
15	Elevator Detector Edge	2013	3,238		20	162	162	162	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)		\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912	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		\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912	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		\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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		\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912		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)	\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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		\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912	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)	\$ 14,387,559	\$ 524,997		\$ 462,486	\$ (62,511)	\$ 10,519,912	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9	Various	2008	741,248		20	37,063	37,063	222,374	9
10	Various	2009	431,004		20	24,430	24,430	122,151	10
11	Roofing & Coating	2010	17,500		20	875	875	3,500	11
12	Driveway Concrete	2010	13,000		20	650	650	2,600	12
13	Tuckpointing & Chimney	2010	226,755		20	11,338	11,338	45,351	13
14	Fire Doors	2010	13,020		20	651	651	2,604	14
15	Building Improvements- Lighting 2nd Floor Laundry	2010	4,720		20	236	236	944	15
16	HVAC Upgrade	2010	200,420		20	10,021	10,021	40,084	16
17	Laundry Room- Drain Waste/ Vent and Gas Piping	2010	14,125		20	706	706	2,825	17
18	Lintel Replacement	2010	20,000		20	1,000	1,000	4,000	18
19	Admin Office- Pegasus Custom Furniture	2010	11,255		20	563	563	2,251	19
20	Boiler Work	2010	13,290		20	665	665	2,660	20
21	Lighting- Rooms	2010	82,400		20	4,120	4,120	16,480	21
22	Oxygen Rooms- Lighting, Exhaust fan Duct work	2010	7,200		20	360	360	1,440	22
23	Window Treatments	2010	11,109		20	555	555	2,221	23
24	Window Treatments	2010	5,475		20	274	274	1,095	24
25	Window Treatments	2010	7,690		20	385	385	1,539	25
26	Building Improvements- Nurse Station Work	2010	12,000		20	600	600	2,400	26
27	Paint Basement Ceiling	2010	12,600		20	630	630	2,520	27
28	Tuckpointing	2010	3,000		20	150	150	600	28
29	Satellite System Wiring & Installation	2010	11,682		20	584	584	2,336	29
30	Duct Heater	2010	3,492		20	175	175	699	30
31	Kitchen Sink & Faucet	2011	2,882		20	144	144	432	31
32	Paint Basement Ceiling	2011	12,600		20	2,676	2,676	8,028	32
33	Carpeting	2011	3,931		20	190	190	570	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	1
2	Steam Trap	2011	8,810		20	135	135	405	2
3	Window Treatment-Admin	2011	2,738		20	137	137	411	3
4	Door Locks	2011	15,141		20	757	757	2,271	4
5	Ceiling Grid Replacement	2011	191,786		20	9,589	9,589	28,768	5
6	Television Wiring	2011	25,463		20	1,273	1,273	3,819	6
7	Smoke Tower Project	2011	69,599		20	3,480	3,480	10,440	7
8	Replace Window Air Conditioners	2011	3,801		20	190	190	570	8
9	Catch Basin, Drains in Bathroom	2011	2,700		20	135	135	405	9
10	Custom Built in Furniture	2012	5,000		20	250	250	500	10
11	Metal Doors	2012	46,654		20	2,333	2,333	4,666	11
12	Vent and Boiler Pumps	2012	3,487		20	174	174	348	12
13	Garage Ceilings	2012	3,350		20	168	168	336	13
14	Plaster/Paint Dining Room	2012	8,200		20	410	410	820	14
15	Kitchen Floor Tiles	2012	9,072		20	454	454	908	15
16	Floor Repairs	2012	3,208		20	160	160	320	16
17	Replace Sprinklers	2012	5,030		20	252	252	504	17
18	Loading Dock Repairs	2012	2,950		20	148	148	296	18
19	Boiler Work 1 And 2	2013	21,514		20	1,076	1,076	1,076	19
20	Freezer Condensate Unit	2013	4,966		20	248	248	248	20
21	Boiler Work	2013	74,985		20	3,749	3,749	3,749	21
22	Awning	2013	2,653		20	133	133	133	22
23	Communication System Speakers	2013	3,260		20	163	163	163	23
24	HVAC- Condensate Unit	2013	2,978		20	149	149	149	24
25	Replace Floor Drain/ Sewer	2013	3,800		20	190	190	190	25
26	Replace Kitchen Drain	2013	3,800		20	190	190	190	26
27									27
28									28
29	Building Company Improvement Depreciation Total			122,439			(122,439)		29
30									30
31									31
32									32
33									33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ 2,407,343	\$ 122,439		\$ 124,984	\$ 2,545	\$ 553,389	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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	SIR Properties - SIR Management	2009	37,872		39	971	971	3,925	3
4	SIR Properties - SIR Management	1993	68,573	2,177	35	1,959	(218)	40,163	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Alloc. - S.I.R. Management	1993	17,385	484	20	148	(336)	17,385	9
10	Alloc. - S.I.R. Management	1994	54		20			54	10
11	Alloc. - S.I.R. Management	1995	397		20	20	20	366	11
12	Alloc. - S.I.R. Management	1997	26,714	598	20	1,302	704	22,359	12
13	Alloc. - S.I.R. Management	1999	2,100		20	105	105	1,496	13
14	Alloc. - S.I.R. Management	1999	23,330		20			23,330	14
15	Alloc. - S.I.R. Management	2000	2,480		20	124	124	1,679	15
16	Alloc. - S.I.R. Management	2007	7,968	544	20	398	(146)	2,468	16
17	Alloc. - S.I.R. Management	2008	21,960	2,098	20	1,384	(714)	8,090	17
18	Alloc. - S.I.R. Management	2009	54,567	499	20	2,728	2,229	11,580	18
19	Alloc. - S.I.R. Management	2011	1,350	135	20	135		326	19
20	Alloc. - S.I.R. Management	2012	4,320	216	20	215	(1)	305	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	4,200	579	20	29	(550)	34	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	4,138		20	207	207	690	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	4,117	184	20	206	22	988	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	1,201	95	20	60	(35)	420	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	272		20	14	14	157	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	8,689		20	434	434	6,300	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	4,152		20	208	208	3,218	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	258		20	13	13	226	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	653	17	20	33	16	636	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	1,112	6	20	27	21	1,112	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

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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		\$	\$		\$	\$	\$	\$	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	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 297,862	\$ 7,632		\$ 10,720	\$ 3,088	\$ 147,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,010,719	\$ 62,053	\$ 86,734	\$ 24,681	10	\$ 553,346	71
72	Current Year Purchases	5,316		44	44	10	44	72
73	Fully Depreciated Assets	1,115,890		47	47	10	1,115,890	73
74								74
75	TOTALS	\$ 2,131,925	\$ 62,053	\$ 86,825	\$ 24,772		\$ 1,669,280	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Chevy Express Van	2010	\$ 35,076	\$ 3,516	\$	\$ (3,516)	5	\$	76
77		Allocated from SIR Management	2011	5,325	557	636	79	5	2,499	77
78										78
79										79
80	TOTALS			\$ 40,401	\$ 4,073	\$ 636	\$ (3,437)		\$ 2,499	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)	\$ 16,644,443	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 591,123	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 549,947	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (41,176)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,191,691	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning: 01/01/13

Ending: 12/31/13

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 23,888

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

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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): <a href="#">See Supplemental</a>															13
14	<b>TOTAL</b>			\$		\$		\$			\$			\$		14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care# 0037762Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 90,499	\$ 355,268	1
2	Cash-Patient Deposits	62,662	62,662	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,023,094	2,023,094	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,980	110,482	6
7	Other Prepaid Expenses	4,289	4,289	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,240,524	\$ 2,555,795	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,382,029	5,802,558	15
16	Equipment, at Historical Cost	2,363,788	2,993,659	16
17	Accumulated Depreciation (book methods)	(3,574,075)	(9,429,688)	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):		776,048	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,171,742	\$ 7,495,116	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,412,266	\$ 10,050,911	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 361,062	\$ 471,862	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	89,666	89,666	28
29	Short-Term Notes Payable	170,000	170,000	29
30	Accrued Salaries Payable	527,047	527,047	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,304	15,304	31
32	Accrued Real Estate Taxes(Sch.IX-B)		560,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	27,000	27,000	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	50,064	50,064	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,240,143	\$ 1,910,943	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		37,988,441	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43			2,639,133	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 40,627,574	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,240,143	\$ 42,538,517	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,172,123	\$ (32,487,606)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,412,266	\$ 10,050,911	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,998,449</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,998,449</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>173,674</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>173,674</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,172,123</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,409,950	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,409,950	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	759	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 759	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	96,201	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 96,201	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,506,910	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	2,149,076	31
32	Health Care	3,880,385	32
33	General Administration	3,196,393	33
<b>B. Capital Expense</b>			
34	Ownership	3,478,059	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	60,000	35
36	Provider Participation Fee	569,323	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,333,236	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	173,674	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 173,674	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 13,182,700	44
45	Private Pay - Net Inpatient Revenue	227,250	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 13,409,950	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	1,943	2,086	\$ 114,855	\$ 55.06	1
2	Assistant Director of Nursing	3,730	4,160	126,678	30.45	2
3	Registered Nurses	1,920	2,135	66,503	31.15	3
4	Licensed Practical Nurses	34,648	37,798	911,323	24.11	4
5	CNAs & Orderlies	103,005	113,560	1,314,729	11.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,847	6,506	57,273	8.80	8
9	Activity Director	3,223	3,683	84,800	23.02	9
10	Activity Assistants	20,671	22,684	255,021	11.24	10
11	Social Service Workers	29,437	31,645	443,459	14.01	11
12	Dietician					12
13	Food Service Supervisor	1,779	2,086	61,628	29.54	13
14	Head Cook	3,639	4,049	55,526	13.71	14
15	Cook Helpers/Assistants	23,878	26,913	290,839	10.81	15
16	Dishwashers					16
17	Maintenance Workers	5,253	5,910	68,533	11.60	17
18	Housekeepers	27,270	29,683	316,566	10.66	18
19	Laundry					19
20	Administrator	1,865	2,086	147,769	70.84	20
21	Assistant Administrator	1,992	2,086	54,846	26.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,566	30,247	422,017	13.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,130	7,926	180,017	22.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	304,796	335,243	\$ 4,972,382 *	\$ 14.83	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	22,707	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Consultant- Specialized Rehab	Monthly	50,040	10a-03	47
48	Consultant- Psychiatric Director	Monthly	7,200	03-10	48
49	TOTAL (lines 35 - 48)		\$ 256,227		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	1,601	56,515	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,601	\$ 56,515		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dennis Tossi	Administrator	3.11	\$ 147,769	Workers' Compensation Insurance	\$ 44,325	IDPH License Fee	\$ 1,992	
Elizabeth Webster	Asst. Admin.	0	54,846	Unemployment Compensation Insurance	49,625	Advertising: Employee Recruitment		
				FICA Taxes	380,387	Health Care Worker Background Check		
				Employee Health Insurance	219,273	(Indicate # of checks performed <u>109</u> )	1,090	
				Employee Meals	20,294	Patient Background Checks	5,108	
				Illinois Municipal Retirement Fund (IMRF)*		Alloc. SIR Management	858	
				Union Pension	16,422	Dues and Subscriptions	1,426	
				401K Matching	5,525	Dues and Subsc- Alliance	1,177	
				Employee Benefits- Other	6,483	Licenses and Permits	25,480	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 202,615	TOTAL (agree to Schedule V, line 22, col.8)		\$ 37,130		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
SIR Management- Dir of Admin Services	\$ 100,080						Out-of-State Travel	\$
SIR Management- Consulting Fee	672,886							
Director Fees- Michael Giannini	30,000						In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 802,966	TOTAL		\$	Seminar Expense	3,104
C. Professional Services								
Vendor/Payee	Type	Amount						
SIR Management	Accounting	\$ 36,000					Alloc. SIR Management	
SIR Management	Dir of Regulatory Services	50,040					1,788	
SIR Management	Bookkeeping Fees	165,132						
Plante Moran	Accounting- 401K	1,200					Entertainment Expense	
FR&R	Accounting	13,140					(	
Pinnacle	Customer Satisfaction	2,561					(agree to Sch. V, line 24, col. 8)	
Personnel Planner	Unemployment consulting	2,601					\$ 4,892	
HK Payroll Services	Payroll Consulting	998						
Amari & Locallo	R/E Appeal	47,432						
Property Valuation Services	Appraisal	3,000						
Legat Architects	Architecture	58						
See Supplemental Schedule		5,853						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 328,015					

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

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Albany Care

# 0037762

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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- 58864
- (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. \$ 675 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. \$ 569,323  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 20,294 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.