FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0037762

Facility Name: Albany Care Inc

Address: 901 Maple (Number) Evanston (City) 60202 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) STEVEN LAVENDA, CPA, Partner
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	47,771	936	73,143	121,850	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,771	936	73,143	121,850	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.06%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Albany Care Inc # 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	387,977	68,631	71,091	527,699		527,699	(34,060)	493,639			1
2	Food Purchase		566,136		566,136	(21,608)	544,528	(43)	544,485			2
3	Housekeeping	301,833	72,276		374,109		374,109		374,109			3
4	Laundry		19,508	39,256	58,764		58,764		58,764			4
5	Heat and Other Utilities			294,369	294,369		294,369	(20,710)	273,659			5
6	Maintenance	54,302	42,896	238,854	336,052		336,052	(24,606)	311,446			6
7	Other (specify):*							11,990	11,990			7
8	**TOTAL General Services**	744,112	769,447	643,570	2,157,129	(21,608)	2,135,521	(67,430)	2,068,091			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,497,328	63,752	194,353	2,755,433		2,755,433	(19,298)	2,736,135			10
10a	Therapy	41,982		70,056	112,038		112,038	(33,415)	78,623			10a
11	Activities	289,845	24,692		314,537		314,537		314,537			11
12	Social Services	393,860		7,800	401,660		401,660		401,660			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							15,240	15,240			15
16	**TOTAL Health Care and Programs**	3,223,015	88,444	275,809	3,587,268		3,587,268	(37,473)	3,549,795			16
	C. General Administration											
17	Administrative	241,480		801,182	1,042,662		1,042,662	(533,339)	509,323			17
18	Directors Fees											18
19	Professional Services			510,604	510,604	(22,010)	488,594	(340,484)	148,110			19
20	Dues, Fees, Subscriptions & Promotions			131,555	131,555		131,555	(62,854)	68,701			20
21	Clerical & General Office Expenses	411,208	98,264	71,867	581,339		581,339	195,034	776,373			21
22	Employee Benefits & Payroll Taxes			783,091	783,091	21,608	804,699	(7,200)	797,499			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,975	5,975		5,975	174	6,149			24
25	Other Admin. Staff Transportation			27,977	27,977		27,977	4,133	32,110			25
26	Insurance-Prop.Liab.Malpractice			277,311	277,311		277,311	36,162	313,473			26
27	Other (specify):*							86,047	86,047			27
28	**TOTAL General Administration**	652,688	98,264	2,609,562	3,360,514	(402)	3,360,112	(622,326)	2,737,786			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,619,815	956,155	3,528,941	9,104,911	(22,010)	9,082,901	(727,230)	8,355,671			29

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

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

Facility Name & ID Number Albany Care Inc #0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			122,277	122,277		122,277	259,814	382,091			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,845	4,845		4,845	1,265,665	1,270,510			32
33	Real Estate Taxes					22,010	22,010	632,541	654,551			33
34	Rent-Facility & Grounds			3,228,700	3,228,700		3,228,700	(3,228,700)				34
35	Rent-Equipment & Vehicles			15,311	15,311		15,311	11,181	26,492			35
36	Other (specify):*							202,998	202,998			36
37	**TOTAL Ownership**			3,371,133	3,371,133	22,010	3,393,143	(856,501)	2,536,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			60,000	60,000		60,000	(60,000)				43
44	**TOTAL Special Cost Centers**			60,000	60,000		60,000	(60,000)				44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,619,815	956,155	6,960,074	12,536,044		12,536,044	(1,643,731)	10,892,313			45

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(25,836)	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	(173,783)	30		9
10	Interest and Other Investment Income	(9,277)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(33,333)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,456)	21		24
25	Fund Raising, Advertising and Promotional	(7,538)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,594)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(137,048)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (397,908)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,245,822)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,245,822)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,643,731)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Albany Care Inc

ID# 0037762

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (6,799)	21	1
2	PAC Dues - Alliance for Living	(25,533)	20	2
3	Non-Allowable Legal Fees	(14,592)	19	3
4	Capitalized R&M	(4,785)	06	4
5	Misc Income	(52)	21	5
6	Directors Fees	(60,000)	43	6
7				7
8				8
9	Building Co:			9
10	Amortization	(4,858)	36	10
11	Office Expense	(12)	21	11
12	Filing Fees	(350)	21	12
13	Professional Fees	(8,300)	19	13
14	Capitalized R&M	(11,768)	06	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(137,048)		49

Albany Care Inc

ID# 0037762

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care Inc # 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(34,060)								(34,060)	1
2	Food Purchase	(43)											(43)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(25,836)			5,126								(20,710)	5
6	Maintenance	(16,553)	20,755	(55,000)	26,191								(24,606)	6
7	Other (specify):*				11,990								11,990	7
8	**TOTAL General Services**	(42,432)	20,755	(55,000)	9,247								(67,430)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(36,248)	17,624	(674)							(19,298)	10
10a	Therapy				(33,415)								(33,415)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,644	7,596								15,240	15
16	**TOTAL Health Care and Programs**			(28,604)	(8,195)	(674)							(37,473)	16
	C. General Administration													
17	Administrative			(713,888)	180,549								(533,339)	17
18	Directors Fees													18
19	Professional Services	(22,892)	8,300	(360,214)	34,322								(340,484)	19
20	Fees, Subscriptions & Promotions	(66,404)		3,550									(62,854)	20
21	Clerical & General Office Expenses	(18,263)	362	212,707	228								195,034	21
22	Employee Benefits & Payroll Taxes			(7,200)									(7,200)	22
23	Inservice Training & Education													23
24	Travel and Seminar			174									174	24
25	Other Admin. Staff Transportation			4,133									4,133	25
26	Insurance-Prop.Liab.Malpractice		31,084	4,582	496								36,162	26
27	Other (specify):*			47,103	38,944								86,047	27
28	**TOTAL General Administration**	(107,558)	39,746	(809,053)	254,539								(622,326)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(149,990)	60,501	(892,657)	255,591	(674)							(727,230)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Albany Care Inc** **#** **0037762** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(173,783)	417,734		15,863								259,814	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,277)	1,291,524	(30,689)	14,107								1,265,665	32
33	Real Estate Taxes		614,229		18,312								632,541	33
34	Rent-Facility & Grounds		(3,228,700)										(3,228,700)	34
35	Rent-Equipment & Vehicles			11,181									11,181	35
36	Other (specify):*	(4,858)	207,856										202,998	36
37	**TOTAL Ownership**	(187,918)	(697,357)	(19,508)	48,282								(856,501)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,000)											(60,000)	43
44	**TOTAL Special Cost Centers**	(60,000)											(60,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(397,908)	(636,856)	(912,165)	303,873	(674)							(1,643,731)	45

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 3,228,700	Albany, LLC	100.00%	$	$ (3,228,700)	1
2	V	21	Filing Fees		Albany, LLC	100.00%	350	350	2
3	V	32	Interest	382	Albany, LLC	100.00%	1,291,906	1,291,524	3
4	V	36	MIP Insurance Exp		Albany, LLC	100.00%	202,998	202,998	4
5	V	21	Office Expense		Albany, LLC	100.00%	12	12	5
6	V	19	Professional Fees		Albany, LLC	100.00%	8,300	8,300	6
7	V	26	Property Insurance		Albany, LLC	100.00%	31,084	31,084	7
8	V	33	Real Estate Tax Exp- Net	17,771	Albany, LLC	100.00%	632,000	614,229	8
9	V	06	Repairs - B&E		Albany, LLC	100.00%	20,755	20,755	9
10	V	36	Amortization		Albany, LLC	100.00%	4,858	4,858	10
11	V	30	Depreciation		Albany, LLC	100.00%	417,734	417,734	11
12	V								12
13	V								13
14	Total			$ 3,246,853			$ 2,609,997	$ * (636,856)	14

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 60,048	S.I.R. MANAGEMENT, INC.	100.00%	$ 10,748	$ (49,300)	15
16	V								16
17	V	10	NURSING	120,096	S.I.R. MANAGEMENT, INC.	100.00%	83,848	(36,248)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	7,644	7,644	18
19	V	19	PROFESSIONAL FEES	369,864	S.I.R. MANAGEMENT, INC.	100.00%	8,675	(361,189)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	3,550	3,550	20
21	V	21	CLERICAL & GENERAL	20,016	S.I.R. MANAGEMENT, INC.	100.00%	271,895	251,879	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	2,574	2,574	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	15,233	15,233	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	4,582	4,582	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,395	14,395	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(30,689)	(30,689)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	12,310	12,310	27
28	V	35	EQUIPMENT RENTAL	3,300	S.I.R. MANAGEMENT, INC.	100.00%	2,171	(1,129)	28
29	V								29
30	V	17	ADMINISTRATIVE	771,182	S.I.R. MANAGEMENT, INC.	100.00%	57,294	(713,888)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	975	975	31
32	V	21	CLERICAL & GENERAL	70,380	S.I.R. MANAGEMENT, INC.	100.00%	31,208	(39,172)	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	32,708	32,708	33
34	V	17	MGT FEES		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V	06	REPAIRS AND MAINT.	5,700				(5,700)	35
36	V	25	OTHER ADMIN. STAFF TRANS.	11,100				(11,100)	36
37	V	22	EMPLOYEE BENEFITS	7,200				(7,200)	37
38	V	24	EDUCATION & SEMINAR	2,400				(2,400)	38
39	Total			$ 1,441,286			$ 529,121	$ * (912,165)	39

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 50,040	S.I.R. MANAGEMENT, INC.	100.00%	$ 15,980	$ (34,060)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,228	2,228	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	17,624	17,624	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	2,440	2,440	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	180,549	180,549	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	34,153	34,153	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	38,944	38,944	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	70,056	S.I.R. MANAGEMENT, INC.	100.00%	36,641	(33,415)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,156	5,156	25
26	V								26
27	V	6	MAINTENANCE SALARIES	41,919	S.I.R. MANAGEMENT, INC.	100.00%	65,231	23,312	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	9,762	9,762	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	5,126	5,126	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	2,879	2,879	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	169	169	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	228	228	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	496	496	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	15,863	15,863	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	14,107	14,107	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	18,312	18,312	37
38	V								38
39	Total			$ 162,015			$ 465,888	$ * 303,873	39

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 51,066	MAC Rx, LLC	100.00%	$ 50,392	$ (674)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 51,066			$ 50,392	$ * (674)	39

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 RECOVABLE 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	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	RANAN WOLFF	1.438849	ELMWOOD CARE INC	ELMWOOD PARK	LONGTERM CARE LAB	ELK GROVE VILLAGE	LABORATORY	5
6	TZIONA ZEFFRN	1.438850	OAKTON PAVILION	DES PLAINES	MAC Rx LLC	DES PLAINES	PHARMACY CONSULTANT	6
7	ARI WOLFF	1.438848	GREENWOOD CARE INC	EVANSTON				7
8	CHERYL MAGENCE	1.438849	WESLEY REHABILITATION CENTER	AUBURN, IN				8
9	ERIC ROTHNER	4.556355	NEIGHBORS REHABILTATION 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						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	NORMAN MATTHEW QSST	7.9532						27
28	SHELDON ROBINSON TRUST	4.374101						28
29	FREDA ROBINSON TRUST DTD 10/21/83	4.374101						29
30								30

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 B. MATTHEW REVOCABLE TRUST	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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	N/A	See Attached	6.76	15.02%	Alloc. Salary	$ 33,790	17-7	1
2	Kirsten Schloss	Relative	Maintenance	N/A	See Attached	8.45	16.90%	Alloc. Salary	16,274	6-7	2
3	Sarah Barrish	Relative	Administrative	N/A	See Attached	7.60	16.89%	Alloc. Salary	17,799	17-7	3
4	Louise Bergthold	Owner	Administrative	.719425	See Attached	10.14	16.90%	Alloc. Salary	33,790	17-7	4
5	Michael Giannini	Relative	Administrative	N/A	See Attached	5.91	14.78%	Fee/Alloc.Sal	58,887	17-3;17-7	5
6	Nenita Guzman	Relative	Dietary	N/A	See Attached	8.45	16.90%	Alloc. Salary	15,980	1-7	6
7	Patricia McDiarmid	Owner	Administrative	.4796177	See Attached	8.45	16.90%	Alloc. Salary	27,884	17-7	7
8	Jeff Oravec	Owner	Administrative	.479617	See Attached	6.76	16.90%	Alloc. Salary	23,504	17-7	8
9	Dennis Tossi	Owner	Administrative	3.117%	See Attached	40.00	100.00%	Alloc. Salary	152,584	17-1	9
10	See Supplemental Schedule								40,774		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	$ 421,266		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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	721,222	14	$ 63,617	$	121,850	$ 10,748	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	121,850	83,848	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		121,850	7,644	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		121,850	8,675	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		121,850	3,550	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	121,850	271,895	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		121,850	2,574	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		121,850	15,233	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		121,850	4,582	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		121,850	14,395	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		121,850	(30,689)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		121,850	12,310	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		121,850	2,171	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	121,850	57,294	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		121,850	975	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	121,850	31,208	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		121,850	32,708	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 529,121	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	721,222	14	$ 94,587	$ 94,587	121,850	$ 15,980	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		121,850	2,228	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	121,850	17,624	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		121,850	2,440	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	121,850	180,549	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		121,850	34,153	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		121,850	38,944	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	70,056	36,641	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		70,056	5,156	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	41,919	65,231	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		41,919	9,762	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		2,176	5,126	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		2,176	2,879	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		2,176	169	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		2,176	228	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		2,176	496	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		2,176	15,863	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		2,176	14,107	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		2,176	18,312	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 465,888	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] NO [ ]

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

Name of Related Organization: MAC Rx
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 50,392	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					$	$		$ 50,392	25

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Capital		X	Mortgage			$	$ 36,581,461			$ 1,291,906	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HP Bank		X	Line of Credit				150,000			4,845	6
7	Alloc. SIR Management	X									14,107	7
8												8
9	TOTAL Facility Related						$	$ 36,731,461			$ 1,310,858	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,277)	10
11	Interest Income- BLDG Co	X									(382)	11
12	Alloc. SIR Management	X									(30,689)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (40,348)	14
15	TOTALS (line 9+line14)						$	$ 36,731,461			$ 1,270,509	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 202,998 **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.)**

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Albany Care Inc # 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 620,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 620,541	2
3. Under or (over) accrual (line 2 minus line 1).		$ 541	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 632,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$ 22,010	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 87,038 **For** 11 & 12 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 654,551	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	506,302	8
	2011	508,858	9
	2012	533,112	10
	2013	588,323	11
	2014	602,229	12

Accrual= $602229 x 1.05= $632,000 (rounded)

Alloc. -SIR Management: $18,312

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-19-121-019-0000	Long Term Care Property	$ 602,229.01	$ 602,229.01
2.	See Attached	Allocated from SIR Mgt	$ 118,674.75	$ 15,704.24
3.	See Attached	Allocated from Regency	$ 862,948.02	$ 1,770.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,583,851.78	$ 619,703.41

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility	24,573		$ 84,558	1
2					2
3	TOTALS	24,573		$ 84,558	3

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	417		1991	1972	$ 7,267,981	$ 417,734	35	$	$ (417,734)	$ 7,267,981	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	61,428		20			61,421	9
10	Various			1994	120,534		20			120,526	10
11	Various			1995	291,499		20	11,755	11,755	290,677	11
12	Various			1996	58,666		20	2,933	2,933	57,258	12
13	Various			1997	72,445		20	3,505	3,505	66,303	13
14	Various			1998	177,216		20	8,861	8,861	156,908	14
15	Various			1999	239,104		20	11,955	11,955	194,431	15
16	Various			2000	239,704		20	11,615	11,615	184,447	16
17	Various			2001	370,037		20	14,996	14,996	300,499	17
18	Various			2002	887,772		20	21,805	21,805	340,240	18
19	Various			2003	489,239		20	3,825	3,825	461,357	19
20	Various			2004	261,729		20	13,086	13,086	152,133	20
21	Various			2005	211,692		20	10,585	10,585	111,797	21
22	Various			2006	47,928		20	2,652	2,652	25,019	22
23	Various			2007	752,722		20	37,949	37,949	325,162	23
24	Various			2008	15,271		20	974	974	7,307	24
25	Various			2009	26,337		20	1,317	1,317	8,546	25
26	Various			2010	4,295		20	215	215	1,092	26
27	Various			2011	40,863		20	3,318	3,318	13,614	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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	Related Building Company (Pages 12F & 12G)		2,465,122			127,093	127,093	806,492	67
68	Related Party Allocations (Pages 12H & 12I)		372,466	9,853		12,818	2,965	191,652	68
69	Financial Statement Depreciation			122,277			(122,277)		69
70	TOTAL (lines 4 thru 69)		$ 14,474,050	$ 549,864		$ 301,258	$ (248,606)	$ 11,144,860	70

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,474,050	$ 549,864		$ 301,258	$ (248,606)	$ 11,144,860	1
2	Replace Compressor 1&2 On Dining Rm Unit	2012	3,572		20	357	357	1,250	2
3	Drain Repairs	2012	2,600		20	260	260	823	3
4	Interior Lighting	2013	21,310		20	1,066	1,066	3,197	4
5	Elevator Work	2013	6,832		20	342	342	769	5
6	Water Heater	2013	6,131		20	307	307	639	6
7	New Drain Line & Vent	2013	2,800		20	140	140	292	7
8	Elevator Detector Edge	2013	3,238		20	162	162	364	8
9	Smith Hw Heater	2014	6,358		20	318	318	344	9
10	Repair Boiler #1 And #2	2014	4,975		20	249	249	290	10
11	Remove & Rod Toilets In 2/3Rd Nsg Station & Unit 309	2014	2,800		20	140	140	198	11
12	Recharge Loops For Garage & 7Th Floor, Repair Sprinkler Syste	2014	2,870		20	144	144	155	12
13	Misc Pipe Fittings, Fire Alarm Device, Install Strobes	2014	3,806		20	190	190	222	13
14	Replace 24 Smoke Detectors	2014	6,759		20	338	338	563	14
15	Video Camera & Monitors	2015	2,791		20	23	23	23	15
16	Repaired Elevator Equip For Water Damage	2015	4,785		20	239	239	239	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)		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	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)		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	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
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	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)		$ 14,555,676	$ 549,864		$ 305,531	$ (244,333)	$ 11,154,229	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	741,248		20	37,063	37,063	296,500	9
10	Various	2009	431,004		20	24,430	24,430	171,011	10
11	Various	2010	690,733		20	34,538	34,538	207,225	11
12	Kitchen Sink & Faucet	2011	2,882		20	144	144	720	12
13	Paint Basement Ceiling	2011	12,600		20	1,896	1,896	12,600	13
14	Carpeting	2011	3,931		20	190	190	950	14
15	Steam Trap	2011	8,810		20	135	135	675	15
16	Window Treatment-Admin	2011	2,738		20	137	137	685	16
17	Door Locks	2011	15,141		20	757	757	3,785	17
18	Ceiling Grid Replacement	2011	191,786		20	9,589	9,589	47,946	18
19	Television Wiring	2011	25,463		20	1,273	1,273	6,365	19
20	Smoke Tower Project	2011	69,599		20	3,480	3,480	17,400	20
21	Replace Window Air Conditioners	2011	3,801		20	190	190	950	21
22	Catch Basin, Drains in Bathroom	2011	2,700		20	135	135	675	22
23	Custom Built in Furniture	2012	5,000		20	250	250	1,000	23
24	Metal Doors	2012	46,654		20	2,333	2,333	9,332	24
25	Vent and Boiler Pumps	2012	3,487		20	174	174	696	25
26	Garage Ceilings	2012	3,350		20	168	168	672	26
27	Plaster/Paint Dining Room	2012	8,200		20	410	410	1,640	27
28	Kitchen Floor Tiles	2012	9,072		20	454	454	1,816	28
29	Floor Repairs	2012	3,208		20	160	160	640	29
30	Replace Sprinklers	2012	5,030		20	252	252	1,008	30
31	Loading Dock Repairs	2012	2,950		20	148	148	592	31
32	Boiler Work 1 And 2	2013	21,514		20	1,076	1,076	3,228	32
33	Freezer Condensate Unit	2013	4,966		20	248	248	744	33
34	TOTAL (lines 1 thru 33)		$ 2,315,867	$		$ 119,630	$ 119,630	$ 788,855	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,315,867	$		$ 119,630	$ 119,630	$ 788,855	1
2	Boiler Work	2013	74,985		20	3,749	3,749	11,247	2
3	Awning	2013	2,653		20	133	133	399	3
4	Communication System Speakers	2013	3,260		20	163	163	489	4
5	HVAC- Condensate Unit	2013	2,978		20	149	149	447	5
6	Replace Floor Drain/ Sewer	2013	3,800		20	190	190	570	6
7	Replace Kitchen Drain	2013	3,800		20	190	190	570	7
8	Install remote annunciator behind receptionist desk	2014	4,232		20	212	212	424	8
9	Repair 2 compressors plug and contactors	2014	6,990		20	349	349	698	9
10	Security camera and DVD	2014	6,508		20	325	325	650	10
11	Remove toilet 2nd & 3rd Nurses station/rod and repair	2014	2,800		20	140	140	280	11
12									12
13									13
14	Boiler Storage Tank	2015	10,102		20	505	505	505	14
15	Sprinkler System Devices	2015	4,596		20	230	230	230	15
16	Install Elevator MCE F5 Drive	2015	7,588		20	379	379	379	16
17	HVAC- Compressor (dining room)	2015	3,196		20	160	160	160	17
18									18
19	New Steam Lines at Kitchen	2015	6,300		20	315	315	315	19
20	HVAC Compressor on Commissary Unit	2015	2,868		20	143	143	143	20
21	Replace Boiler Piping	2015	2,600		20	130	130	130	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)		$ 2,465,122	$		$ 127,093	$ 127,093	$ 806,492	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	S.I.R. Management	2009	84,485	2,166	39	2,166		13,088	3
4	SIR Properties - S.I.R. Management	1993	76,487	2,428	35	2,185	(243)	49,169	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	19,392	540	20		(540)	19,392	9
10	Alloc. - S.I.R. Management	1994	60		20			60	10
11	Alloc. - S.I.R. Management	1995	443		20	13	13	443	11
12	Alloc. - S.I.R. Management	1997	29,797	667	20	1,452	785	27,845	12
13	Alloc. - S.I.R. Management	1999	2,343		20	117	117	1,903	13
14	Alloc. - S.I.R. Management	1999	23,330		20			23,330	14
15	Alloc. - S.I.R. Management	2000	2,766		20	138	138	2,149	15
16	Alloc. - S.I.R. Management	2007	8,888		20	444	444	3,641	16
17	Alloc. - S.I.R. Management	2008	24,494	2,449	20	1,544	(905)	12,111	17
18	Alloc. - S.I.R. Management	2009	60,864	557	20	3,043	2,486	19,003	18
19	Alloc. - S.I.R. Management	2011	1,506	151	20	151		665	19
20	Alloc. - S.I.R. Management	2012	4,819	241	20	241		823	20
21	Alloc. - S.I.R. Management	2014	676	68	20	34	(34)	54	21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	4,685	329	20	16	(313)	84	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	4,616		20	231	231	1,231	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	4,593	205	20	230	25	1,561	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	1,339	27	20	67	40	603	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	303		20	15	15	205	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	9,692		20	485	485	7,996	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	4,632		20	232	232	4,053	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	288		20	14	14	275	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	728	19	20		(19)	728	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	1,240	6	20		(6)	1,240	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 372,466	$ 9,853		$ 12,818	$ 2,965	$ 191,652	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 372,466	$ 9,853		$ 12,818	$ 2,965	$ 191,652	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
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 372,466	$ 9,853		$ 12,818	$ 2,965	$ 191,652	34

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 998,339	$ 5,492	$ 75,915	$ 70,423	10	$ 646,099	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,178,338		11	11	10	1,178,338	73
74								74
75	TOTALS	$ 2,176,677	$ 5,492	$ 75,926	$ 70,434		$ 1,824,437	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated fron SIR Management	2015	$ 5,940	$ 519	$ 635	$ 116	5	$ 4,057	76
77										77
78										78
79										79
80	TOTALS			$ 5,940	$ 519	$ 635	$ 116		$ 4,057	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)	$ 16,822,851	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 555,875	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 382,092	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (173,783)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,982,723	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.

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 14,182 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	Allocated from S.I.R. Management		$	$ 12,310	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,310	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.

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Albany Care Inc # 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 39,097	$ 312,506	1
2	Cash-Patient Deposits	44,275	44,275	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,963,813	1,963,813	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,834	126,657	6
7	Other Prepaid Expenses	4,285	4,285	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,338	1,338	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,109,642	$ 2,452,874	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,388,387	5,834,398	15
16	Equipment, at Historical Cost	2,366,580	2,996,451	16
17	Accumulated Depreciation (book methods)	(3,833,339)	(10,523,451)	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):		1,058,571	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,921,628	$ 6,718,508	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,031,270	$ 9,171,382	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 291,255	$ 291,255	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,305	44,305	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	349,372	349,372	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,784	14,784	31
32	Accrued Real Estate Taxes(Sch.IX-B)		632,000	32
33	Accrued Interest Payable		106,696	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	25,500	25,500	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	40,708	40,708	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 765,924	$ 1,504,620	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	150,000	150,000	39
40	Mortgage Payable		36,581,461	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	91,999	2,470,690	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 241,999	$ 39,202,151	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,007,923	$ 40,706,771	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,023,347	$ (31,535,389)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,031,270	$ 9,171,382	48

***(See instructions.)**

Facility Name & ID Number Albany Care Inc **#** 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,127,263	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,127,263	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	271,384	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(375,300)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (103,916)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,023,347	24 *

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

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,711,061	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,711,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,277	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,277	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	87,090	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 87,090	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,807,428	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,157,129	31
32	Health Care	3,587,268	32
33	General Administration	3,360,514	33
	B. Capital Expense		
34	Ownership	3,371,133	34
	C. Ancillary Expense		
35	Special Cost Centers	60,000	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,536,044	40
41	**Income before Income Taxes (line 30 minus line 40)****	271,384	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 271,384	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,951,027	44
45	Private Pay - Net Inpatient Revenue	113,102	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	7,646,932	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,711,061	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.**

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,725	2,086	$ 121,072	$ 58.04	1
2	Assistant Director of Nursing	1,942	2,183	60,368	27.65	2
3	Registered Nurses	1,344	1,597	48,322	30.26	3
4	Licensed Practical Nurses	33,751	37,785	888,612	23.52	4
5	CNAs & Orderlies	91,971	102,814	1,202,231	11.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,662	4,898	41,982	8.57	8
9	Activity Director					9
10	Activity Assistants	20,424	23,596	289,845	12.28	10
11	Social Service Workers	25,184	27,430	393,860	14.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,531	32,699	387,977	11.87	15
16	Dishwashers					16
17	Maintenance Workers	3,740	4,229	54,302	12.84	17
18	Housekeepers	25,176	28,110	301,833	10.74	18
19	Laundry					19
20	Administrator	1,806	2,086	152,584	73.15	20
21	Assistant Administrator	3,695	4,146	88,896	21.44	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,239	28,857	411,208	14.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,836	7,819	176,723	22.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	278,026	310,335	$ 4,619,815 *	$ 14.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 71,091	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	3,528	10-03	37
38	Nurse Consultant	Monthly	120,096	10-03	38
39	Pharmacist Consultant	Monthly	36,901	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	70,056	03-10a	47
48	Consultant - Psychiatric Director	Monthly	7,800	03-12	48
49	TOTAL (lines 35 - 48)		$ 313,072		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	930	33,828	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	930	$ 33,828		53

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Tossi	Administrator	3.11%	$ 152,584
Joshua Behr	Asst Admin in Training	0%	27,461
Cynthia Schofield	Asst Admin	0%	61,435
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 241,480

B. Administrative - Other

Description	Amount
Director Fees - Michael Giannini	$ 30,000
SIR Management- Dir of Admin Services	120,096
SIR Management- Consulting Fee	651,086
TOTAL (agree to Schedule V, line 17, col. 3)	$ 801,182
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FRR / Marcum LLP	Accounting Fees	$ 21,875
SIR Management	Computer Support	55,044
McGladrey	Accounting Fees	1,450
SIR Management	Dir of Regulatory Services	60,048
SIR Management	Bookkeeping Fees	175,140
SIR Management	Dir of Financial Services	39,600
Pinnacle	Customer Satisfaction	1,377
Paychex	Payroll	17,142
Legat Architects	Architecture	4,508
See Attached Scheduled	Legal Fees	37,826
Personnel Planner	Unemployment Consultant	1,517
See Supplemental Schedule		95,076
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 510,603

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,844
Unemployment Compensation Insurance	35,205
FICA Taxes	352,358
Employee Health Insurance	271,943
Employee Meals	21,608
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	37,157
401K Matching	7,100
Employee Benefits- Other	10,285
TOTAL (agree to Schedule V, line 22, col.8)	$ 797,499

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 25,620
Advertising: Employee Recruitment	1,200
Health Care Worker Background Check	
(Indicate # of checks performed 154)	1,540
Patient Background Checks	2,837
Dues & Subscriptions	2,544
Dues & Sub - Alliance	28,563
Licenses & Permits	2,847
Allocated from SIR	3,550
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 68,701

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,575
Allocated from SIR	2,574
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,149

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

Facility Name & ID Number Albany Care Inc # 0037762 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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- 54096**

(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. $ **2,265** 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. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,608** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.