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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0037762

Facility Name: Albany Care

Address: 901 Maple Avenue (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: Steven N. 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 01/01/16 to 12/31/16 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)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	152,622	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,622	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	37,493	1,048	83,402	121,943	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,493	1,048	83,402	121,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.90%

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Albany Care # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	380,544	68,464	68,088	517,096		517,096	(33,783)	483,313			1
2	Food Purchase		554,087		554,087	(21,228)	532,859	(47)	532,812			2
3	Housekeeping	303,182	75,033		378,215		378,215	(5,391)	372,824			3
4	Laundry		29,987	40,230	70,217		70,217	(2)	70,215			4
5	Heat and Other Utilities			293,948	293,948		293,948	(22,646)	271,302			5
6	Maintenance	53,120	40,016	279,520	372,656		372,656	(54,128)	318,528			6
7	Other (specify):*							8,142	8,142			7
8	**TOTAL General Services**	736,846	767,587	681,786	2,186,219	(21,228)	2,164,991	(107,854)	2,057,137			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600	2,568	6,168			9
10	Nursing and Medical Records	2,483,742	67,130	230,745	2,781,617		2,781,617	(27,328)	2,754,289			10
10a	Therapy	34,260		70,056	104,316		104,316	(33,894)	70,422			10a
11	Activities	278,777	25,817		304,594		304,594		304,594			11
12	Social Services	410,286		7,420	417,706		417,706		417,706			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							20,784	20,784			15
16	**TOTAL Health Care and Programs**	3,207,065	92,947	311,821	3,611,833		3,611,833	(37,870)	3,573,963			16
	C. General Administration											
17	Administrative	255,321		825,056	1,080,377		1,080,377	(524,917)	555,460			17
18	Directors Fees											18
19	Professional Services			508,827	508,827	(19,023)	489,804	(351,689)	138,115			19
20	Dues, Fees, Subscriptions & Promotions			115,327	115,327		115,327	(43,942)	71,385			20
21	Clerical & General Office Expenses	478,705	97,724	106,166	682,595		682,595	237,159	919,754			21
22	Employee Benefits & Payroll Taxes			724,163	724,163	21,228	745,391	(174)	745,217			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,005	10,005		10,005	204	10,209			24
25	Other Admin. Staff Transportation			26,785	26,785		26,785	17,733	44,518			25
26	Insurance-Prop.Liab.Malpractice			301,246	301,246		301,246	35,870	337,116			26
27	Other (specify):*							81,786	81,786			27
28	**TOTAL General Administration**	734,026	97,724	2,617,575	3,449,325	2,205	3,451,530	(547,969)	2,903,561			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,677,937	958,258	3,611,182	9,247,377	(19,023)	9,228,354	(693,694)	8,534,660			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 #0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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			117,400	117,400		117,400	253,156	370,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,266,359	1,266,359			32
33	Real Estate Taxes					19,023	19,023	665,211	684,234			33
34	Rent-Facility & Grounds			3,216,000	3,216,000		3,216,000	(3,216,000)				34
35	Rent-Equipment & Vehicles			15,438	15,438		15,438	9,800	25,238			35
36	Other (specify):*							198,988	198,988			36
37	**TOTAL Ownership**			3,348,838	3,348,838	19,023	3,367,861	(822,486)	2,545,375			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)**	4,677,937	958,258	7,020,020	12,656,215		12,656,215	(1,576,180)	11,080,035			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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	(27,501)	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	(179,774)	30		9
10	Interest and Other Investment Income	(4,244)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(17,137)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,068)	21		24
25	Fund Raising, Advertising and Promotional	(4,767)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,842)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(21,402)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (286,782)		$	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)	(1,289,398)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,289,398)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,576,180)		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

Albany Care

ID# 0037762

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non - Allowable Legal Fees	$ (49)	19	1
2	Bank Fees	(6,978)	21	2
3	Bldg Co. Amortization	(4,858)	36	3
4	Bldg Co. Office Expense	(12)	21	4
5	Bldg Co. Filing Fees	(350)	21	5
6	Bldg Co. Professional Fees	(8,700)	19	6
7	Additional R&M	1,949	06	7
8	Capitalized R&M	(28,580)	06	8
9	Directors Fees	(60,000)	43	9
10	Misc Income	(656)	21	10
11	PAC Dues	(26,237)	20	11
12	Prior Year Pharm. Expense	(2,500)	10	12
13	Prior Year Seminar Expense	(1,000)	24	13
14	Amort. Of Bond Premium	116,619	36	14
15	Jury Duty	(50)	10	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**	(21,402)		49

Albany Care

ID# 0037762

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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 # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(33,277)	(506)							(33,783)	1
2	Food Purchase	(47)											(47)	2
3	Housekeeping					(5,391)							(5,391)	3
4	Laundry					(2)							(2)	4
5	Heat and Other Utilities	(27,501)			4,855								(22,646)	5
6	Maintenance	(26,631)	9,807	(46,531)	9,227								(54,128)	6
7	Other (specify):*				8,142								8,142	7
8	**TOTAL General Services**	(54,179)	9,807	(46,531)	(11,053)	(5,899)							(107,854)	8
	B. Health Care and Programs													
9	Medical Director			2,568									2,568	9
10	Nursing and Medical Records	(2,550)		(35,471)	18,160	(3,564)	(3,903)						(27,328)	10
10a	Therapy				(33,894)								(33,894)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,225	9,559								20,784	15
16	**TOTAL Health Care and Programs**	(2,550)		(21,678)	(6,175)	(3,564)	(3,903)						(37,870)	16
	C. General Administration													
17	Administrative			(736,861)	211,944								(524,917)	17
18	Directors Fees													18
19	Professional Services	(8,749)	8,700	(387,090)	35,450								(351,689)	19
20	Fees, Subscriptions & Promotions	(48,141)		4,199									(43,942)	20
21	Clerical & General Office Expenses	(39,906)	362	276,393	310								237,159	21
22	Employee Benefits & Payroll Taxes						(174)						(174)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,000)		1,204									204	24
25	Other Admin. Staff Transportation			17,733									17,733	25
26	Insurance-Prop.Liab.Malpractice		31,135	4,306	429								35,870	26
27	Other (specify):*			29,895	51,891								81,786	27
28	**TOTAL General Administration**	(97,796)	40,197	(790,221)	300,024		(174)						(547,969)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(154,525)	50,004	(858,430)	282,797	(9,463)	(4,077)						(693,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(179,774)	417,655		15,275								253,156	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,244)	1,265,898	(9,987)	14,692								1,266,359	32
33	Real Estate Taxes		646,985		18,226								665,211	33
34	Rent-Facility & Grounds		(3,216,000)										(3,216,000)	34
35	Rent-Equipment & Vehicles			9,800									9,800	35
36	Other (specify):*	111,761	87,227										198,988	36
37	**TOTAL Ownership**	(72,257)	(798,235)	(187)	48,193								(822,486)	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)**	(286,782)	(748,231)	(858,617)	330,990	(9,463)	(4,077)						(1,576,180)	45

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 3,216,000	Albany, LLC	100.00%	$	$ (3,216,000)	1
2	V	21	Filing Fees		Albany, LLC	100.00%	350	350	2
3	V	32	Interest Income/Mortgage	475	Albany, LLC	100.00%	1,266,373	1,265,898	3
4	V	36	MIP Insurance Exp		Albany, LLC	100.00%	198,988	198,988	4
5	V	21	Office Expense		Albany, LLC	100.00%	12	12	5
6	V	19	Professional Fees		Albany, LLC	100.00%	8,700	8,700	6
7	V	26	Property Insurance		Albany, LLC	100.00%	31,135	31,135	7
8	V	33	Real Estate Tax Exp-Net	8,015	Albany, LLC	100.00%	655,000	646,985	8
9	V	06	Repairs - B&E		Albany, LLC	100.00%	9,807	9,807	9
10	V	36	Amortization		Albany, LLC	100.00%	4,858	4,858	10
11	V	30	Depreciation		Albany, LLC	100.00%	417,655	417,655	11
12	V	36	Amort. Of Bond Premium	116,619	Albany, LLC	100.00%		(116,619)	12
13	V								13
14	Total			$ 3,341,109			$ 2,592,878	$ * (748,231)	14

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 13,517	$ (46,531)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,568	2,568	16
17	V	10	NURSING	120,096	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	84,625	(35,471)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,225	11,225	18
19	V	17	ADMINISTRATIVE	795,057	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	58,196	(736,861)	19
20	V	19	PROFESSIONAL FEES	397,284	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	10,194	(387,090)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,199	4,199	21
22	V	21	CLERICAL & GENERAL	20,016	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	296,409	276,393	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,204	1,204	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	17,733	17,733	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,306	4,306	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	29,895	29,895	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(9,987)	(9,987)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,072	11,072	28
29	V	35	EQUIPMENT RENTAL	3,300	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,028	(1,272)	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			$ 1,395,801			$ 537,184	$ * (858,617)	39

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 16,763	$ (33,277)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,935	2,935	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	18,160	18,160	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,166	3,166	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	211,944	211,944	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	34,245	34,245	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	51,891	51,891	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	70,056	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	36,162	(33,894)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,393	6,393	25
26	V								26
27	V	6	MAINTENANCE SALARIES	21,992	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	29,314	7,322	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,207	5,207	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,855	4,855	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,905	1,905	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,205	1,205	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	310	310	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	429	429	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	15,275	15,275	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	14,692	14,692	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	18,226	18,226	37
38	V								38
39	Total			$ 142,088			$ 473,077	$ * 330,990	39

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,904	Big Ten Supply, LLC	100.00%	$ 6,398	$ (506)	15
16	V	3	Housekeeping	73,579	Big Ten Supply, LLC	100.00%	68,188	(5,391)	16
17	V	4	Laundry	29	Big Ten Supply, LLC	100.00%	27	(2)	17
18	V	6	Repairs & Maintenance		Big Ten Supply, LLC	100.00%			18
19	V	10	Nursing And Medical Records	48,649	Big Ten Supply, LLC	100.00%	45,085	(3,564)	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			$ 129,161			$ 119,698	$ * (9,463)	39

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 54,192	MAC Rx, LLC	100.00%	$ 50,289	$ (3,903)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits	2,414	MAC Rx, LLC	100.00%	2,240	(174)	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			$ 56,606			$ 52,529	$ * (4,077)	39

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	GENERATIONS AT REGENCY, LLC	NILES	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	NOAH WOLFF REVOCABLE TRUST	4.357315	GENERATIONS AT APPLEWOOD, LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	MARILYN WOLFF RECOVABLE TRUST	4.357314	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	LAURI WOLFF POLEN	1.438848	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	RANAN WOLFF	1.438849	DECATUR MANOR HEALTHCARE,LLC	DECATUR	MAC Rx LLC	DES PLAINES	PHARMACY CONS	5
6	TZIONA ZEFFRN	1.438850	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	GENERATIONS HEALTH NETW	LINCOLNWOOD	MANAGEMENT CO.	6
7	ARI WOLFF	1.438848	GREENWOOD CARE, INC.	EVANSTON	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	7
8	CHERYL MAGENCE	1.438849	GENERATIONS AT NEIGHBORS, LLC	BYRON				8
9	ERIC ROTHNER	4.556355	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10	MELISSA ROTHNER TRUST	1.199040	WILSON CARE, INC.	CHICAGO				10
11	DANIEL ROTHNER TRUST	1.199041	AUBURN VILLAGE	AUBURN, IN				11
12	WILLIAM ROTHNER TRUST	1.199041	GENERATIONS AT OAKTON, LLC	DES PLAINES				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 & STEPHANIE WINTER REV. TRUST	.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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	BARRY & GAIL	2.386091						3
4	EDWARD B. MATTHEW REVOCABLE TRUST	2.6511						4
5	KENNETH MATTHEW	2.651080						5
6	SAMUEL MATTHEW/ BRO TRUST	1.3255						6
7	HARRISON MATTHEW/ BRO TRUST	1.3255						7
8	NATHAN ROTHNER TRUST	1.438849						8
9	SHIRLEY ROTHNER TRUST	1.438849						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	0%	See Attached	6.85	15.22%	Alloc. Salary	$ 34,245	17-07	1
2	Kirsten Schloss	Relative	Maintenance	0%	See Attached	8.56	17.12%	Alloc. Salary	16,354	6-7	2
3	Sarah Barrish	Relative	Administrative	0%	See Attached	8.56	17.12%	Alloc. Salary	21,114	17-7	3
4	Louise Bergthold	Owner	Administrative	0.72%	See Attached	10.27	17.12%	Alloc. Salary	34,245	17-7	4
5	Michael Giannini	Relative	Administrative	0%	See Attached	5.99	14.98%	Fee/Alloc.Sal	59,109	17-3;17-7	5
6	Nenita Guzman	Relative	Dietary	0%	See Attached	8.56	17.12%	Alloc. Salary	16,763	1-7	6
7	Patricia McDiarmid	Owner	Administrative	0.48%	See Attached	10.27	17.12%	Alloc. Salary	28,507	17-7	7
8	Jeff Oravec	Owner	Administrative	0.48%	See Attached	6.85	17.13%	Alloc. Salary	23,950	17-7	8
9	Dennis Tossi	Owner	Administrative	3.117%	See Attached	40	100.00%	Alloc. Salary	160,711	17-1	9
10	See Supplemental Schedule								44,021		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	$ 439,019		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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: SIR MGMT.INC & GENERATIONS HC NETW
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	712,171	14	$ 78,945	$	121,943	$ 13,518	1
2	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	712,171	14	15,000		121,943	2,568	2
3	10	NURSING	PATIENT DAYS	712,171	14	494,227		121,943	84,625	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	712,171	14	65,558	494,227	121,943	11,225	4
5	17	ADMINISTRATIVE	PATIENT DAYS	712,171	14	339,874	339,874	121,943	58,196	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	712,171	14	59,533		121,943	10,194	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	712,171	14	24,522		121,943	4,199	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	712,171	14	1,731,089	1,318,665	121,943	296,409	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	712,171	14	7,033		121,943	1,204	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	712,171	14	103,561		121,943	17,732	10
11	26	INSURANCE	PATIENT DAYS	712,171	14	25,150		121,943	4,306	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	712,171	14	174,591		121,943	29,895	12
13	32	INTEREST	PATIENT DAYS	712,171	14	(58,326)		121,943	(9,987)	13
14	35	AUTO RENTAL	PATIENT DAYS	712,171	14	64,663		121,943	11,072	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	712,171	14	11,842		121,943	2,028	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,137,262	$ 2,152,767		$ 537,184	25

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: SIR MGMT.INC & GENERATIONS HC NETW
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	712,171	14	$ 97,898	$ 97,898	121,943	$ 16,763	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		121,943	2,935	2
3	10	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	121,943	18,160	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		121,943	3,166	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	121,943	211,944	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		121,943	34,245	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		121,943	51,891	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	70,056	36,162	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		70,056	6,393	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	21,992	29,314	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		21,992	5,207	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		2,205	4,856	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		2,205	1,906	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		2,205	1,205	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		2,205	310	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		2,205	429	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		2,205	15,275	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		2,205	14,692	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		2,205	18,226	23
24										24
25	TOTALS					$ 3,035,001	$ 1,932,526		$ 473,079	25

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: Big Ten Supply, LLC
Street Address: 15632 West Sprucewood Lane
City / State / Zip Code: Libertyville, IL 60048
Phone Number: (312)502-5882
Fax Number: (847)816-3425

	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	Direct Allocation			$	$		$ 6,398	1
2	3	Housekeeping	Direct Allocation						68,188	2
3	4	Laundry	Direct Allocation						27	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing And Medical Records	Direct Allocation						45,085	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					$	$		$ 119,698	25

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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, LLC
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			$	$		$ 50,289	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation						2,240	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					$	$		$ 52,529	25

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Capital		X	Mortgage			$	$ 35,840,221			$ 1,266,373	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Alloc. SIR/Generations HN	X									14,692	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 35,840,221			$ 1,281,065	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,244)	10
11	Interest Income - Bldg Co.	X									(475)	11
12	Alloc. SIR/Generations HN	X									(9,987)	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (14,706)	14
15	TOTALS (line 9+line14)						$	$ 35,840,221			$ 1,266,359	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 198,988 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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 632,000	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.)		$ 642,211	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,211	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 655,000	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.)**		$ 19,023	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** $ 307 **For** 2004 **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.		$ 684,234	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	508,858	8
	2012	533,112	9
	2013	588,323	10
	2014	602,229	11
	2015	623,985	12

2016 Accrual = $623,985 x 1.05 = $655,000 (rounded)

Alloc. - SIR/Generations HN: $18,226

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 623,985.46	$ 623,985.46
2.	13-31-401-046-0000	Allocation from Regency	$ 890,957.88	$ 1,853.50
3.	See Attached	Allocated from SIR/Generations HN	$ 123,678.12	$ 16,584.46
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,638,621.46	$ 642,423.42

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 417,655	35	$	$ (417,655)	$ 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	813	813	291,489	11
12	Various			1996	58,666		20	1,402	1,402	58,661	12
13	Various			1997	72,445		20	3,505	3,505	69,808	13
14	Various			1998	177,216		20	8,861	8,861	165,769	14
15	Various			1999	239,104		20	11,955	11,955	206,386	15
16	Various			2000	239,704		20	11,615	11,615	196,062	16
17	Various			2001	370,037		20	14,996	14,996	315,495	17
18	Various			2002	887,772		20	21,805	21,805	362,045	18
19	Various			2003	489,239		20	3,825	3,825	465,182	19
20	Various			2004	261,729		20	13,086	13,086	165,219	20
21	Various			2005	211,692		20	10,585	10,585	122,381	21
22	Various			2006	47,928		20	2,156	2,156	27,175	22
23	Various			2007	752,722		20	37,949	37,949	363,111	23
24	Various			2008	15,271		20	974	974	8,281	24
25	Various			2009	26,337		20	1,317	1,317	9,863	25
26	Various			2010	4,295		20	215	215	1,306	26
27	Various			2011	40,863		20	3,318	3,318	16,932	27
28	Various			2012	6,172		20	617	617	2,691	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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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)		2,500,751			128,874	128,874	933,470	67
68	Related Party Allocations (Pages 12H & 12I)		378,008	9,125		13,214	4,089	207,741	68
69	Financial Statement Depreciation			117,400			(117,400)		69
70	TOTAL (lines 4 thru 69)		$ 14,521,392	$ 544,180		$ 291,083	$ (253,097)	$ 11,438,996	70

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 14,521,392	$ 544,180		$ 291,083	$ (253,097)	$ 11,438,996	1
2	Interior Lighting	2013	21,310		20	1,066	1,066	4,262	2
3	Elevator Work	2013	6,832		20	342	342	1,110	3
4	Water Heater	2013	6,131		20	307	307	945	4
5	New Drain Line & Vent	2013	2,800		20	140	140	432	5
6	Elevator Detector Edge	2013	3,238		20	162	162	526	6
7	Smith Hw Heater	2014	6,358		20	318	318	662	7
8	Repair Boiler #1 And #2	2014	4,975		20	249	249	539	8
9	Remove & Rod Toilets In 2/3Rd Nsg Station & Unit 309	2014	2,800		20	140	140	338	9
10	Recharge Loops For Garage & 7Th Floor, Repair Sprinkler Syster	2014	2,870		20	144	144	299	10
11	Misc Pipe Fittings, Fire Alarm Device, Install Strobes	2014	3,806		20	190	190	412	11
12	Replace 24 Smoke Detectors	2014	6,759		20	338	338	901	12
13	Video Camera & Monitors	2015	2,791		20	140	140	151	13
14	Repaired Elevator Equipment For Water Damage	2015	4,785		20	239	239	359	14
15	Tuckpointing	2016	9,158		20	38	38	38	15
16	Supply & Install Carpet Tile On Ramps & Hallways	2016	3,591		20	180	180	180	16
17	Reweld & Repipe Boiler	2016	2,510		20	126	126	126	17
18	Replace Drain Line & Fittings For Boiler System	2016	3,600		20	180	180	180	18
19	Door Installation On Stairwell Second Floor	2016	3,633		20	182	182	182	19
20	Steel Pipe Repair Basement & Crawlspace	2016	4,600		20	230	230	230	20
21	Elevator Repair - Changed Aux Relays	2016	2,557		20	128	128	128	21
22	Repair & Replace Car Hangers	2016	5,564		20	278	278	278	22
23	Repaired Elevator Pm Relay & Door Operator	2016	2,525		20	126	126	126	23
24	Elevator - Retractable Pit Repair	2016	3,510		20	176	176	176	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)		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	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)		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	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)		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	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)		$ 14,638,095	$ 544,180		$ 296,500	$ (247,680)	$ 11,451,577	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									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	333,563	9
10	Various	2009	431,004		20	24,430	24,430	195,441	10
11	Various	2010	690,733		20	34,538	34,538	241,763	11
12	Kitchen Sink & Faucet	2011	2,882		20	144	144	864	12
13	Paint Basement Ceiling	2011	12,600		20	1,896	1,896	12,600	13
14	Carpeting	2011	3,931		20	190	190	1,140	14
15	Steam Trap	2011	8,810		20	135	135	810	15
16	Window Treatment-Admin	2011	2,738		20	137	137	822	16
17	Door Locks	2011	15,141		20	757	757	4,542	17
18	Ceiling Grid Replacement	2011	191,786		20	9,589	9,589	57,535	18
19	Television Wiring	2011	25,463		20	1,273	1,273	7,638	19
20	Smoke Tower Project	2011	69,599		20	3,480	3,480	20,880	20
21	Replace Window Air Conditioners	2011	3,801		20	190	190	1,140	21
22	Catch Basin, Drains in Bathroom	2011	2,700		20	135	135	810	22
23	Custom Built in Furniture	2012	5,000		20	250	250	1,250	23
24	Metal Doors	2012	46,654		20	2,333	2,333	11,665	24
25	Vent and Boiler Pumps	2012	3,487		20	174	174	870	25
26	Garage Ceilings	2012	3,350		20	168	168	840	26
27	Plaster/Paint Dining Room	2012	8,200		20	410	410	2,050	27
28	Kitchen Floor Tiles	2012	9,072		20	454	454	2,270	28
29	Floor Repairs	2012	3,208		20	160	160	800	29
30	Replace Sprinklers	2012	5,030		20	252	252	1,260	30
31	Loading Dock Repairs	2012	2,950		20	148	148	740	31
32	Boiler Work 1 And 2	2013	21,514		20	1,076	1,076	4,304	32
33	Freezer Condensate Unit	2013	4,966		20	248	248	992	33
34	TOTAL (lines 1 thru 33)		$ 2,315,867	$		$ 119,630	$ 119,630	$ 906,589	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 906,589	1
2	Boiler Work	2013	74,985		20	3,749	3,749	14,996	2
3	Awning	2013	2,653		20	133	133	532	3
4	Communication System Speakers	2013	3,260		20	163	163	652	4
5	HVAC- Condensate Unit	2013	2,978		20	149	149	596	5
6	Replace Floor Drain/ Sewer	2013	3,800		20	190	190	760	6
7	Replace Kitchen Drain	2013	3,800		20	190	190	760	7
8	Install remote annunciator behind receptionist desk	2014	4,232		20	212	212	635	8
9	Repair 2 compressors plug and contactors	2014	6,990		20	349	349	1,048	9
10	Security camera and DVD	2014	6,508		20	325	325	976	10
11	Remove toilet 2nd & 3rd Nurses station/rod and repair	2014	2,800		20	140	140	420	11
12									12
13									13
14	Boiler Storage Tank	2015	10,102		20	505	505	1,010	14
15	Sprinkler System Devices	2015	4,596		20	230	230	460	15
16	Install Elevator MCE F5 Drive	2015	7,588		20	379	379	758	16
17	HVAC- Compressor (dining room)	2015	3,196		20	160	160	320	17
18									18
19	New Steam Lines at Kitchen	2015	6,300		20	315	315	630	19
20	HVAC Compressor on Commissary Unit	2015	2,868		20	143	143	286	20
21	Replace Boiler Piping	2015	2,600		20	130	130	260	21
22	Replace Tub Drains in rooms 302/303	2016	3,600		20	180	180	180	22
23	Boiler Work	2016	8,178		20	409	409	409	23
24	Digangi Plumbing & Replaced Storage Tank	2016	8,400		20	420	420	420	24
25	Urban Elevator Service - Elevator GAL Door Opener	2016	15,451		20	773	773	773	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 2,500,751	$		$ 128,874	$ 128,874	$ 933,470	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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/Generations HN	2009	85,611	2,195	39	2,195		15,458	3
4	SIR Properties - S.I.R. Management/Generations HN	1993	77,506	2,460	35	2,214	(246)	52,039	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management/Generations HN	1993	19,650	547	20		(547)	19,650	9
10	Alloc. - S.I.R. Management/Generations HN	1994	61		20			61	10
11	Alloc. - S.I.R. Management/Generations HN	1995	449		20			449	11
12	Alloc. - S.I.R. Management/Generations HN	1997	30,194		20	1,472	1,472	29,688	12
13	Alloc. - S.I.R. Management/Generations HN	1999	2,374		20	119	119	2,047	13
14	Alloc. - S.I.R. Management/Generations HN	1999	23,330		20			23,330	14
15	Alloc. - S.I.R. Management/Generations HN	2000	2,803		20	140	140	2,319	15
16	Alloc. - S.I.R. Management/Generations HN	2007	9,006		20	450	450	4,140	16
17	Alloc. - S.I.R. Management/Generations HN	2008	24,821	2,482	20	1,564	(918)	13,837	17
18	Alloc. - S.I.R. Management/Generations HN	2009	61,675	564	20	3,084	2,520	22,340	18
19	Alloc. - S.I.R. Management/Generations HN	2011	1,526	153	20	153		826	19
20	Alloc. - S.I.R. Management/Generations HN	2012	4,883	244	20	244		1,079	20
21	Alloc. - S.I.R. Management/Generations HN	2014	685	68	20	34	(34)	89	21
22	Alloc. - S.I.R. Management/Generations HN	2016	890	18	20	18		18	22
23	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	2012	4,748	238	20	237	(1)	951	23
24	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	2010	4,677		20	234	234	1,481	24
25	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	2009	4,654	104	20	233	129	1,815	25
26	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	2007	1,357	27	20	68	41	679	26
27	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	2002	307		20	15	15	224	27
28	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	1999	9,821		20	491	491	8,593	28
29	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	1998	4,693		20	235	235	4,341	29
30	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	1997	292		20	14	14	292	30
31	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	1994	738	19	20		(19)	738	31
32	Alloc. - S.I.R. Properties - S.I.R. Management/Generations HN	1993	1,257	6	20		(6)	1,257	32
33									33
34	TOTAL (lines 1 thru 33)		$ 378,008	$ 9,125		$ 13,214	$ 4,089	$ 207,741	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		$ 378,008	$ 9,125		$ 13,214	$ 4,089	$ 207,741	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)		$ 378,008	$ 9,125		$ 13,214	$ 4,089	$ 207,741	34

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 959,553	$ 5,565	$ 73,064	$ 67,499	10	$ 679,604	71
72	Current Year Purchases	5,180	58	415	357	10	415	72
73	Fully Depreciated Assets	1,220,151		55	55	10	1,220,151	73
74								74
75	TOTALS	$ 2,184,884	$ 5,623	$ 73,535	$ 67,912		$ 1,900,170	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 from SIR/Generations]	2016	$ 6,019	$ 526	$ 520	$ (6)	5	$ 4,631	76
77										77
78										78
79										79
80	TOTALS			$ 6,019	$ 526	$ 520	$ (6)		$ 4,631	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)	$ 16,913,556	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 550,329	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,555	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (179,774)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,356,378	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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 14,166 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 SIR/Generations HN		$	$ 11,072	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 11,072	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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 78,547	$ 351,440	1
2	Cash-Patient Deposits	39,120	39,120	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,957,940	1,957,940	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,167	110,638	6
7	Other Prepaid Expenses	9,953	9,953	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	899	1,069,839	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,128,626	$ 3,538,930	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	3,401,055	5,879,095	15
16	Equipment, at Historical Cost	2,368,529	2,998,400	16
17	Accumulated Depreciation (book methods)	(3,950,739)	(11,058,506)	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):		135,212	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,818,845	$ 5,306,740	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,947,471	$ 8,845,670	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 315,382	$ 315,382	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,120	39,120	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	345,627	345,627	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,069	17,069	31
32	Accrued Real Estate Taxes(Sch.IX-B)		655,000	32
33	Accrued Interest Payable		104,534	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	29,000	29,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 746,198	$ 1,505,732	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		35,840,221	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			2,262,072	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 38,102,293	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 746,198	$ 39,608,025	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,201,273	$ (30,762,355)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,947,471	$ 8,845,670	48

***(See instructions.)**

Facility Name & ID Number Albany Care # 0037762 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,023,347	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,023,349	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,174	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	(104,250)	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)**	$ 177,924	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)**	$ 3,201,273	24 *

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

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 12,919,651	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,919,651	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***	4,244	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,244	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,494	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,494	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,938,389	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,186,219	31
32	Health Care	3,611,833	32
33	General Administration	3,449,325	33
	B. Capital Expense		
34	Ownership	3,348,838	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)***	$ 12,656,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 282,174	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,970,487	44
45	Private Pay - Net Inpatient Revenue	138,856	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	8,810,308	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,919,651	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 # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,865	2,091	$ 122,106	$ 58.40	1
2	Assistant Director of Nursing	1,825	2,091	60,685	29.02	2
3	Registered Nurses	1,618	1,706	56,626	33.19	3
4	Licensed Practical Nurses	34,191	36,953	925,199	25.04	4
5	CNAs & Orderlies	84,082	91,703	1,139,820	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,632	3,853	34,260	8.89	8
9	Activity Director					9
10	Activity Assistants	17,485	19,458	278,777	14.33	10
11	Social Service Workers	24,266	25,804	400,253	15.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,008	32,014	380,544	11.89	15
16	Dishwashers					16
17	Maintenance Workers	3,583	4,024	53,120	13.20	17
18	Housekeepers	25,644	27,991	303,182	10.83	18
19	Laundry					19
20	Administrator	1,836	2,091	160,861	76.93	20
21	Assistant Administrator	3,515	4,023	94,460	23.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,548	33,449	478,705	14.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,042	7,842	179,306	22.86	31
32	Other Health Care(specify)					32
33	Other(specify)	2,433	2,433	10,033	4.12	33
34	TOTAL (lines 1 - 33)	273,573	297,526	$ 4,677,937 *	$ 15.72	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	$ 68,088	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,025	10-03	37
38	Nurse Consultant	Monthly	120,096	10-03	38
39	Pharmacist Consultant	Monthly	41,612	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 - Psychiatric Director	Monthly	7,420	03-12	47
48	Consultant - Specialized Rehab	Monthly	70,056	03-10a	48
49	TOTAL (lines 35 - 48)		$ 314,897		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	516	$ 17,690	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,076	47,322	10-03	52
53	TOTAL (lines 50 - 52)	2,592	$ 65,012		53

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Tossi	Administrator	3.11	$ 160,861
Cynthia Schofield	Asst. Admin	0	65,177
Josh Behr	Asst. Admin in Training	0	29,283
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 255,321

B. Administrative - Other

Description	Amount
SIR/Generations HN - Dir. Of Admin Services	$ 120,096
Director Fees - Michael Giannini	30,000
SIR/Generations HN - Consulting Fee	674,961
TOTAL (agree to Schedule V, line 17, col. 3)	$ 825,057
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR/Generations HN	Dir. Of Financial Services	$ 42,000
SIR/Generations HN	Dir. Of Marketing & Admission	85,068
SIR/Generations HN	Dir. Of Regulatory Services	60,048
SIR/Generations HN	Dir. Of IT	25,020
SIR/Generations HN	Bookkeeping Services	185,148
SIR/Generations HN	Computer Support Charges	55,044
Marcum LLP	Accounting Services	15,300
See Attached Schedule	Legal Fees	3,408
Personnel Planner	Unemployment Tax Consultant	1,231
Pinnacle	Customer Satisfaction	1,407
PayChex	Payroll	16,433
See Supplemental Schedule		18,720
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 508,827

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,767
Unemployment Compensation Insurance	28,316
FICA Taxes	348,961
Employee Health Insurance	233,185
Employee Meals	21,228
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	34,952
401K Matching	7,125
Employee Benefits - Other	20,683
TOTAL (agree to Schedule V, line 22, col.8)	$ 745,217

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	$ 1,992
Advertising: Employee Recruitment	1,950
Health Care Worker Background Check	
(Indicate # of checks performed 112)	1,120
Patient Background Checks 421	4,213
Dues & Subscriptions	4,275
Dues & Subscriptions - Alliance	27,859
Licenses & Permits	25,777
Allocated from SIR/Generations HN	4,199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,385

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,005
Allocated from SIR/Generations HN	1,204
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,209

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Albany Care # 0037762 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 - $54,096**

(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. $ **2,169** 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. $ **21,228** 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