		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0054262

Facility Name: Albany Care Inc

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	15,044	1,301	96,955	113,300	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,044	1,301	96,955	113,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.44%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 11/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1991 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	456,991	55,571	53,844	566,406		566,406	(22,105)	544,301			1
2	Food Purchase		555,998		555,998	(22,776)	533,222	(64)	533,158			2
3	Housekeeping	333,994	84,446		418,440		418,440	(7,706)	410,734			3
4	Laundry		32,650	34,498	67,148		67,148	(743)	66,405			4
5	Heat and Other Utilities			303,971	303,971		303,971	(34,845)	269,126			5
6	Maintenance	93,848	48,616	224,456	366,920		366,920	(6,391)	360,529			6
7	Other (specify):*							10,388	10,388			7
8	**TOTAL General Services**	884,833	777,281	616,769	2,278,883	(22,776)	2,256,107	(61,466)	2,194,641			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,773,330	52,785	203,162	3,029,277		3,029,277	(22,509)	3,006,768			10
10a	Therapy	26,120		80,064	106,184		106,184	(26,480)	79,704			10a
11	Activities	297,297	21,290		318,587		318,587		318,587			11
12	Social Services	579,840		7,200	587,040		587,040	(154)	586,886			12
13	CNA Training											13
14	Program Transportation			1,068	1,068		1,068		1,068			14
15	Other (specify):*							23,223	23,223			15
16	**TOTAL Health Care and Programs**	3,676,587	74,075	291,494	4,042,156		4,042,156	(25,920)	4,016,236			16
	C. General Administration											
17	Administrative	230,322		518,110	748,432		748,432	(194,533)	553,899			17
18	Directors Fees											18
19	Professional Services			566,913	566,913	(11,585)	555,328	(405,837)	149,491			19
20	Dues, Fees, Subscriptions & Promotions			106,600	106,600		106,600	(41,283)	65,317			20
21	Clerical & General Office Expenses	299,231	100,626	79,599	479,456		479,456	185,290	664,746			21
22	Employee Benefits & Payroll Taxes			809,234	809,234	22,776	832,010	(9,874)	822,136			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,681	9,681		9,681	(4,249)	5,432			24
25	Other Admin. Staff Transportation			31,888	31,888		31,888	20,702	52,590			25
26	Insurance-Prop.Liab.Malpractice			343,989	343,989		343,989	29,524	373,513			26
27	Other (specify):*							75,306	75,306			27
28	**TOTAL General Administration**	529,553	100,626	2,466,014	3,096,193	11,191	3,107,384	(344,953)	2,762,431			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,090,973	951,982	3,374,277	9,417,232	(11,585)	9,405,647	(432,339)	8,973,308			29

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

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

Facility Name & ID Number Albany Care Inc #0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			103,125	103,125		103,125	253,191	356,316			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,081,668	1,081,668			32
33	Real Estate Taxes					11,585	11,585	748,121	759,706			33
34	Rent-Facility & Grounds			3,304,000	3,304,000		3,304,000	(3,304,000)				34
35	Rent-Equipment & Vehicles			16,504	16,504		16,504	3,486	19,990			35
36	Other (specify):*							190,528	190,528			36
37	**TOTAL Ownership**			3,423,629	3,423,629	11,585	3,435,214	(1,027,006)	2,408,208			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)**	5,090,973	951,982	6,857,906	12,900,861		12,900,861	(1,519,345)	11,381,516			45

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(179,095)	30		9
10	Interest and Other Investment Income	(82,956)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	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	(8,327)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,553)	21		24
25	Fund Raising, Advertising and Promotional	(3,944)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(194,363)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (475,302)		$	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)	(1,044,043)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,044,043)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,519,345)		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 Inc

ID# 0054262

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dues & Subscription	$ (38,958)	05	1
2	Legal Fees	(770)	19	2
3	Bank Fees	(7,002)	21	3
4	Credit Card Fees	(547)	21	4
5	Theft & Damages Loss	(229)	21	5
6	Jury Duty	(52)	10	6
7	PAC Dues	(29,233)	20	7
8	Capitalized R & M	(3,942)	06	8
9	Building Company Office Expenses	(12)	21	9
10	Building Company Filing Fee	(100)	21	10
11	Building Company Professional Fees	(10,500)	19	11
12	Building Company Building Repairs	(15,700)	06	12
13	Building Company Amortization	(4,858)	36	13
14	Building Company State Replacement Tax	(1,707)	21	14
15	Non-Allowable Legal	(9,930)	19	15
16	Non-Allowable Social Service	(154)	12	16
17	Non-Reimbursable Expenses	(60,000)	43	17
18	Miscellaneous Income	(221)	21	18
19	Prior Year Expenses	(518)	21	19
20	Non-Allowable Legal	(9,930)	19	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**	(194,363)		49

Albany Care Inc

ID# 0054262

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(21,421)		(684)						(22,105)	1
2	Food Purchase	(64)											(64)	2
3	Housekeeping						(7,706)						(7,706)	3
4	Laundry						(743)						(743)	4
5	Heat and Other Utilities	(38,958)			4,113								(34,845)	5
6	Maintenance	(19,642)	21,350	(16,442)	8,470		(127)						(6,391)	6
7	Other (specify):*			2,404	7,984								10,388	7
8	**TOTAL General Services**	(58,664)	21,350	(14,038)	(854)		(9,260)						(61,466)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)		(30,297)	15,449	(3,532)	(4,077)						(22,509)	10
10a	Therapy				(26,480)								(26,480)	10a
11	Activities													11
12	Social Services	(154)											(154)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,668	11,555								23,223	15
16	**TOTAL Health Care and Programs**	(206)		(18,629)	524	(3,532)	(4,077)						(25,920)	16
	C. General Administration													
17	Administrative			(433,740)	239,207								(194,533)	17
18	Directors Fees													18
19	Professional Services	(31,130)	10,500	(414,209)	29,002								(405,837)	19
20	Fees, Subscriptions & Promotions	(41,504)		221									(41,283)	20
21	Clerical & General Office Expenses	(16,889)	1,819	200,146	219	(5)							185,290	21
22	Employee Benefits & Payroll Taxes			(9,600)		(274)							(9,874)	22
23	Inservice Training & Education													23
24	Travel and Seminar			(4,249)									(4,249)	24
25	Other Admin. Staff Transportation			20,702									20,702	25
26	Insurance-Prop.Liab.Malpractice		25,953	3,063	508								29,524	26
27	Other (specify):*			19,318	55,988								75,306	27
28	**TOTAL General Administration**	(89,523)	38,272	(618,348)	324,924	(278)							(344,953)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(148,393)	59,622	(651,015)	324,595	(3,811)	(13,337)						(432,339)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care Inc # 0054262 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(179,095)	421,233		11,053								253,191	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(82,956)	1,211,946	(57,341)	10,019								1,081,668	32
33	Real Estate Taxes		732,198		15,923								748,121	33
34	Rent-Facility & Grounds		(3,304,000)										(3,304,000)	34
35	Rent-Equipment & Vehicles			3,486									3,486	35
36	Other (specify):*	(4,858)	195,386										190,528	36
37	TOTAL Ownership	(266,909)	(743,237)	(53,855)	36,995								(1,027,006)	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)	(475,302)	(683,615)	(704,870)	361,590	(3,811)	(13,337)						(1,519,345)	45

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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	Rental Income	$ 3,304,000	Albany Care, LLC		$	$ (3,304,000)	1
2	V	32	Interest	606	Albany Care, LLC		1,212,552	1,211,946	2
3	V	36	Mortgage Insuarnce		Albany Care, LLC		190,528	190,528	3
4	V	21	Office Expense		Albany Care, LLC		12	12	4
5	V	19	Professional Fees		Albany Care, LLC		10,500	10,500	5
6	V	33	Real Estate Taxes		Albany Care, LLC		732,198	732,198	6
7	V	26	Property Insurance		Albany Care, LLC		25,953	25,953	7
8	V	21	Filing Fee		Albany Care, LLC		100	100	8
9	V	36	Amortization		Albany Care, LLC		4,858	4,858	9
10	V	30	Depreciation		Albany Care, LLC		421,233	421,233	10
11	V	06	Repairs		Albany Care, LLC		21,350	21,350	11
12	V	21	Replacement Tax		Albany Care, LLC		1,707	1,707	12
13	V								13
14	Total			$ 3,304,606			$ 2,620,991	$ * (683,615)	14

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	$ 35,028	GENERATIONS HC NETWORK, LLC		$ 26,986	$ (8,042)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		2,404	2,404	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING	100,080	GENERATIONS HC NETWORK, LLC		69,783	(30,297)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		11,668	11,668	19
20	V	17	ADMINISTRATIVE	488,111	GENERATIONS HC NETWORK, LLC		54,371	(433,740)	20
21	V	19	PROFESSIONAL FEES	435,888	GENERATIONS HC NETWORK, LLC		21,679	(414,209)	21
22	V	20	FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		221	221	22
23	V	21	CLERICAL & GENERAL	22,524	GENERATIONS HC NETWORK, LLC		305,770	283,246	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		551	551	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		35,102	35,102	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		3,063	3,063	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		19,318	19,318	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(57,341)	(57,341)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		6,683	6,683	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		1,603	1,603	30
31	V								31
32	V	6	REPAIRS AND MAINT.	8,400	GENERATIONS HC NETWORK, LLC			(8,400)	32
33	V	21	CLERICAL & GENERAL	83,100	GENERATIONS HC NETWORK, LLC			(83,100)	33
34	V	22	EMPLOYEE BENEFITS	9,600	GENERATIONS HC NETWORK, LLC			(9,600)	34
35	V	24	EDUCATION & SEMINAR	4,800	GENERATIONS HC NETWORK, LLC			(4,800)	35
36	V	25	OTHER ADMIN. STAFF TRANS.	14,400	GENERATIONS HC NETWORK, LLC			(14,400)	36
37	V	35	EQUIPMENT RENTAL	4,800	GENERATIONS HC NETWORK, LLC			(4,800)	37
38	V								38
39	Total			$ 1,206,731			$ 501,861	$ * (704,870)	39

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 35,028	GENERATIONS HC NETWORK, LLC		$ 13,607	$ (21,421)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		2,279	2,279	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		15,449	15,449	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		2,570	2,570	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		239,207	239,207	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		28,389	28,389	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		55,988	55,988	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	80,064	GENERATIONS HC NETWORK, LLC		53,584	(26,480)	24
25	V	15	EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC		8,985	8,985	25
26	V								26
27	V	6	MAINTENANCE SALARIES	26,222	GENERATIONS HC NETWORK, LLC		32,314	6,092	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		5,705	5,705	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		4,113	4,113	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC		2,378	2,378	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		613	613	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		219	219	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		508	508	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		11,053	11,053	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		10,019	10,019	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		15,923	15,923	37
38	V								38
39	Total			$ 141,314			$ 502,904	$ * 361,590	39

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	06	Maintenance	$	MAC Rx, LLC		$	$	15
16	V	10	Nursing and Medical Records	40,985	MAC Rx, LLC		37,453	(3,532)	16
17	V	10A	Therapy		MAC Rx, LLC				17
18	V	19	Professional Services		MAC Rx, LLC				18
19	V	21	Clerical & General Office Expenses	53	MAC Rx, LLC		48	(5)	19
20	V	22	Employee Benefits	3,178	MAC Rx, LLC		2,904	(274)	20
21	V	39	Ancillary		MAC Rx, LLC				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			$ 44,216			$ 40,406	$ * (3,811)	39

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 7,146	Big Ten Supply, LLC		$ 6,462	$ (684)	15
16	V	3	Housekeeping	80,468	Big Ten Supply, LLC		72,763	(7,706)	16
17	V	4	Laundry	7,762	Big Ten Supply, LLC		7,019	(743)	17
18	V	6	Repairs & Maintenance	1,324	Big Ten Supply, LLC		1,197	(127)	18
19	V	10	Nursing And Medical Records	42,574	Big Ten Supply, LLC		38,497	(4,077)	19
20	V	10A	Therapy		Big Ten Supply, LLC				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			$ 139,275			$ 125,938	$ * (13,337)	39

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2.386	AUBURN VILLAGE	AUBURN, IN	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	NOAH WOLFF REVOCABLE TRUST	4.357	BRYN MAWR CARE INC.	CHICAGO	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	MARILYN WOLFF RECOVABLE TRUST	4.357	DECATUR MANOR HEALTHCARE,LLC	DECATUR	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	LAURI WOLFF POLEN	1.439	GENERATIONS AT APPLEWOOD, LLC	MATTESON	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	RANAN WOLFF	1.439	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	MAC Rx LLC	DES PLAINES	PHARMACY CONS	5
6	TZIONA ZEFFRN	1.439	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	ARI WOLFF	1.439	GENERATIONS AT NEIGHBORS, LLC	BYRON				7
8	CHERYL MAGENCE	1.439	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES				8
9	ERIC ROTHNER	4.556	GENERATIONS AT REGENCY, LLC	NILES				9
10	MELISSA ROTHNER TRUST	1.199	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				10
11	DANIEL ROTHNER TRUST	1.199	GREENWOOD CARE, INC.	EVANSTON				11
12	WILLIAM ROTHNER TRUST	1.199	WILSON CARE, INC.	CHICAGO				12
13	RACHEL ROTHNER TRUST	1.199	GENERATIONS AT LINCOLN, LLC	LINCOLN				13
14	ADAM VALES TRUST	1.199	GENERATIONS AT MCKINLEY COURT, LLC	DECATUR				14
15	KATHRYN VALES TRUST	1.199	GENERATIONS AT MCKINLEY PLACE, LLC	DECATUR				15
16	DENNIS TOSSI	3.118	GENERATIONS AT PEORIA, LLC	PEORIA				16
17	JEFF ORAVEC	0.480						17
18	CHARLENE HILL- JEON	0.480						18
19	PATRICIA MCDIARMID	0.480						19
20	GLENDA STRICKLAND	1.918						20
21	STEVE AND BARBARA GELLER	2.386						21
22	HARVEY SCOTT	0.480						22
23	LOUISE BERGTHOLD	0.719						23
24	THOMAS & STEPHANIE WINTER REV. TRUST	0.719						24
25	MICHAEL R GIANNINI TRUST DTD 3/13/00	7.314						25
26	CELESTE GIANNINI TRUST DTD 3/13/00	7.314						26
27	NORMAN MATTHEW QSST	7.953						27
28	SHELDON ROBINSON TRUST	4.374						28
29	FREDA ROBINSON TRUST DTD 10/21/83	4.374						29
30								30

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	7.314						1
2	BRYAN BARRISH TRUST DTD 09/01/2004	7.314						2
3	EDWARD B. MATTHEW REVOCABLE TRUST	2.651						3
4	KENNETH MATTHEW	2.651						4
5	SAMUEL MATTHEW/ BRO TRUST	1.326						5
6	HARRISON MATTHEW/ BRO TRUST	1.326						6
7	SHELDON ROBINSON-LEVITT FAMILY TRUST	2.386						7
8	MELISSA ROTHNER	0.719						8
9	DANIEL ROTHNER	0.719						9
10	WILLIAM ROTHNER	0.719						10
11	RACHEL ROTHNER	0.719						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	0.00%	See Attached	4.88	12.19%	Alloc Salary	$ 34,822	17-7	1
2	Sarah Barrish	Relative	Administrative	0.00%	See Attached	6.96	13.93%	Alloc Salary	17,514	17-7	2
3	Louise Bergthold	Owner	Administrative	0.72%	See Attached	8.36	13.93%	Alloc Salary	34,822	17-7	3
4	Thomas Bergthold	Relative	Clerical	0.00%	See Attached	5.57	13.93%	Alloc Salary	6,888	21-7	4
5	Clark Collins	Relative	Administrative	0.00%	See Attached	1.97	4.93%	Alloc Salary	2,463	17-7	5
6	Michael Giannini	Relative	Administrative	0.00%	See Attached	4.88	12.19%	Al Sal/Mgt Fee	55,182	17-7; 17-3	6
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	6.96	13.93%	Alloc Salary	13,607	1-7	7
8	Tom Winter	Relative	Administrative	0.00%	See Attached	8.36	13.93%	Alloc Salary	34,822	17-7	8
9	Jeff Oravec	Owner	Administrative	0.48%	See Attached	5.57	13.93%	Alloc Salary	19,549	17-7	9
10	See Supplemental Page 7								181,407		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	$ 401,076		13

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: GENERATIONS HC NETWORK, LLC
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	813,429	20	$ 193,743	$ 103,385	113,300	$ 26,986	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		113,300	2,404	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			113,300		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	113,300	69,783	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		113,300	11,668	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	113,300	54,371	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		113,300	21,679	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		113,300	221	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	113,300	305,770	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		113,300	551	10
11	25	OTHER ADMIN. STAFF TRANS.	PATIENT DAYS	813,429	20	252,011		113,300	35,102	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		113,300	3,063	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		113,300	19,318	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		113,300	(57,341)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		113,300	6,683	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		113,300	1,603	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,603,079	$ 2,954,641		$ 501,861	25

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: GENERATIONS HC NETWORK, LLC
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	813,429	20	$ 97,690	$ 97,690	113,300	$ 13,607	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		113,300	2,279	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	113,300	15,449	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		113,300	2,570	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	113,300	239,207	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		113,300	28,389	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		113,300	55,988	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	80,064	53,584	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	284,688	14	31,950		80,064	8,985	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	26,222	32,314	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131		26,222	5,705	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		1,794	4,113	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		1,794	2,378	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		1,794	613	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		1,794	219	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		1,794	508	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		1,794	11,053	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		1,794	10,019	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		1,794	15,923	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 502,904	25

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 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	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing And Medical Records	Direct Allocation						37,453	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation						48	5
6	22	Employee Benefits	Direct Allocation						2,904	6
7	39	Ancillary	Direct Allocation							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					$	$		$ 40,406	25

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 6,462	1
2	3	Housekeeping	Direct Allocation						72,763	2
3	4	Laundry	Direct Allocation						7,019	3
4	6	Repairs & Maintenance	Direct Allocation						1,197	4
5	10	Nursing And Medical Records	Direct Allocation						38,497	5
6	10A	Therapy	Direct Allocation							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					$	$		$ 125,938	25

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Capital		X	Mortgage			$	$ 34,277,712			$ 1,212,552	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wintrust Bank		X	Line of Credit								6
7	Alloc. From Generations	X									10,019	7
8												8
9	TOTAL Facility Related						$	$ 34,277,712			$ 1,222,571	9
	B. Non-Facility Related*											
10	Interest Income		X								(82,956)	10
11	Bldg Co Interest Income	X									(606)	11
12	Alloc. From Generations	X									(57,341)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (140,903)	14
15	TOTALS (line 9+line14)						$	$ 34,277,712			$ 1,081,668	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 190,528 Line # 36

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 691,000	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.)		$ 710,121	2
3. Under or (over) accrual (line 2 minus line 1).		$ 19,121	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 729,000	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.)**		$ 11,585	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** $ 43,302 **For** 15 **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.		$ 759,706	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	588,323	8
	2014	602,229	9
	2015	623,985	10
	2016	657,948	11
	2017	694,198	12

2018 Accrual: $694,198 X 1.05 = $729,000 (Rounded)

Allocated From Generations: $15,923

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054262

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 694,198.00	$ 694,198.00
2.	13-31-401-046-0000	Allocation From Regency	$ 899,389.48	$ 761.09
3.	See Attached	Allocation From SIR Properties	$ 137,812.17	$ 15,034.05
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,731,399.65	$ 709,993.14

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054262

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$ 84,558	3

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 421,233	35	$	$ (421,233)	$ 7,267,981	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	61,428		20			61,422	9
10	Various			1994	120,534		20			120,525	10
11	Various			1995	291,499		20			291,490	11
12	Various			1996	58,666		20			58,660	12
13	Various			1997	72,445		20			72,442	13
14	Various			1998	177,216		20	2,581	2,581	177,212	14
15	Various			1999	239,104		20	11,956	11,956	230,298	15
16	Various			2000	239,704		20	11,618	11,618	219,293	16
17	Various			2001	370,037		20	14,997	14,997	334,144	17
18	Various			2002	887,772		20	21,805	21,805	405,655	18
19	Various			2003	489,239		20	3,825	3,825	472,832	19
20	Various			2004	261,729		20	13,086	13,086	191,393	20
21	Various			2005	211,692		20	10,587	10,587	143,549	21
22	Various			2006	47,928		20	2,140	2,140	31,457	22
23	Various			2007	752,722		20	37,690	37,690	438,641	23
24	Various			2008	15,271		20	763	763	10,018	24
25	Various			2009	26,337		20	1,317	1,317	12,497	25
26	Various			2010	4,295		20	215	215	1,736	26
27	Various			2011	40,862		20	3,318	3,318	23,568	27
28	Various			2012	6,172		20	617	617	3,925	28
29	Various			2013	40,311		20	2,017	2,017	11,306	29
30	Various			2014	27,568		20	1,379	1,379	5,908	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
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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)		2,611,494			130,575	130,575	1,196,552	67
68	Related Party Allocations (Pages 12H & 12I)		272,266	5,408		7,917	2,508	179,705	68
69	Financial Statement Depreciation			103,125			(103,125)		69
70	TOTAL (lines 4 thru 69)		$ 14,594,272	$ 529,766		$ 278,403	$ (251,364)	$ 11,962,208	70

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,594,272	$ 529,766		$ 278,403	$ (251,364)	$ 11,962,208	1
2	Video Camera & Monitors	2015	2,791		20	140	140	430	2
3	Repaired Elevator Equipment For Water Damage	2015	4,785		20	239	239	837	3
4	Tuckpointing	2016	9,158		20	458	458	954	4
5	Retractable Pit Ladder	2016	3,510		20	176	176	424	5
6	Supply & Install Carpet Tile On Ramps & Hallways	2016	3,591		20	180	180	494	6
7	Reweld & Repipe Boiler	2016	2,510		20	126	126	293	7
8	Replace Drain Line & Fittings For Boiler System	2016	3,600		20	180	180	405	8
9	Door Installation On Stairwell 2Nd Floor	2016	3,633		20	182	182	378	9
10	Steel Pipe Repair Basement & Crawlspace	2016	4,600		20	230	230	498	10
11	Elevator Repair - Changed Aux Relays	2016	2,557		20	128	128	341	11
12	Repair & Replace Care Hangers	2016	5,564		20	278	278	649	12
13	Repaired Elevator Pm Relay & Door Operator	2016	2,525		20	126	126	337	13
14	Penthouse Tuckpointing	2017	7,950		20	398	398	464	14
15	Elevator Work-Door Operator	2018	16,201		20	405	405	405	15
16	Sewer Upgrade In Basement	2018	6,500		20	135	135	135	16
17	Carpet Tile In Hallway	2018	53,305		20	666	666	666	17
18	Elevator Work-Governor	2018	7,506		20	94	94	94	18
19	Walk-In Cooler Upgrade	2018	6,000		20	25	25	25	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)		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
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)		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 14,740,558	$ 529,766		$ 282,569	$ (247,198)	$ 11,970,037	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	37,062	37,062	407,688	9
10	Various	2009	431,004		20	21,550	21,550	241,421	10
11	Various	2010	690,733		20	34,537	34,537	310,838	11
12	Various	2011	339,451		20	16,973	16,973	141,784	12
13	Custom Built in Furniture	2012	5,000		20	250	250	1,750	13
14	Metal Doors	2012	46,654		20	2,333	2,333	16,329	14
15	Vent and Boiler Pumps	2012	3,487		20	174	174	1,220	15
16	Garage Ceilings	2012	3,350		20	168	168	1,173	16
17	Plaster/Paint Dining Room	2012	8,200		20	410	410	2,870	17
18	Kitchen Floor Tiles	2012	9,072		20	454	454	3,175	18
19	Floor Repairs	2012	3,208		20	160	160	1,123	19
20	Replace Sprinklers	2012	5,030		20	252	252	1,761	20
21	Loading Dock Repairs	2012	2,950		20	148	148	1,033	21
22	Boiler Work 1 And 2	2013	21,514		20	1,076	1,076	6,454	22
23	Freezer Condensate Unit	2013	4,966		20	248	248	1,490	23
24	Boiler Work	2013	74,985		20	3,749	3,749	22,496	24
25	Awning	2013	2,653		20	133	133	796	25
26	Communication System Speakers	2013	3,260		20	163	163	978	26
27	HVAC- Condensate Unit	2013	2,978		20	149	149	893	27
28	Replace Floor Drain/Sewer	2013	3,800		20	190	190	1,140	28
29	Replace Kitchen Drain	2013	3,800		20	190	190	1,140	29
30	Install remote annunciator behind receptionist desk	2014	4,232		20	212	212	1,058	30
31	Repair 2 compressors plug and contactors	2014	6,990		20	350	350	1,748	31
32	Security camera and DVD	2014	6,508		20	325	325	1,627	32
33	Remove toilets 2nd and 3rd Nurses station/rod and repair	2014	2,800		20	140	140	700	33
34	TOTAL (lines 1 thru 33)		$ 2,427,873	$		$ 121,394	$ 121,394	$ 1,172,683	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 2,427,873	$		$ 121,394	$ 121,394	$ 1,172,683	1
2	Boiler Storage Tank	2015	10,102		20	505	505	2,020	2
3	Spinkler System Devices	2015	4,596		20	230	230	919	3
4	Install Elevator MCD F5 Drive	2015	7,588		20	379	379	1,518	4
5	HVAC- Compressor (dining room)	2015	3,196		20	160	160	639	5
6	New Steam Lines at Kitchen	2015	6,300		20	315	315	1,260	6
7	HVAC Compressor on Commissary Unit	2015	2,868		20	143	143	574	7
8	Replace Boiler Piping	2015	2,600		20	130	130	520	8
9	Replace Tub Drains in rooms 302/303	2016	3,600		20	180	180	540	9
10	Boiler Work	2016	8,178		20	409	409	1,227	10
11	Digangi Plumbing & Replaced Storage Tank	2016	8,400		20	420	420	1,260	11
12	Urban Elevator Service- Elevator GAL Door Opener	2016	15,451		20	773	773	2,318	12
13	Wireless WIFI Upgrade	2017	5,275		20	264	264	528	13
14	Boiler Work- Tubes and Manway Cover	2017	5,631		20	282	282	563	14
15	Boiler Work- Tubes Replacement	2017	3,378		20	169	169	338	15
16	Water Softener System	2017	3,116		20	156	156	312	16
17	Stairwell Exit Door	2017	2,865		20	143	143	287	17
18	Eastman Boiler	2017	21,674		20	1,084	1,084	2,167	18
19	Elevator Door Operator	2017	15,979		20	799	799	1,598	19
20	Boiler Work- Component Replacement	2017	8,828		20	441	441	883	20
21	HVAC-Main Exhaust	2017	4,618		20	231	231	462	21
22	Steam Leak Repair- Replacement Piping	2017	17,000		20	850	850	1,700	22
23	Replaced Exterior Lighting	2017	2,554		20	128	128	255	23
24	Boiler Work	2017	4,613		20	231	231	461	24
25	Roof Work	2018	2,700		20	135	135	270	25
26	Plumbing works/ Repair of Shower Valves & Sink Line	2018	3,725		20	186	186	373	26
27	Replace Drain Line from Sink through kitchen floor/ replace Hot & Col	2018	2,850		20	143	143	285	27
28	Remove , Rebuild and re-install Pump motor/ installed new Thermal Re	2018	3,186		20	159	159	319	28
29	Replaced Storage Drain	2018	2,750		20	138	138	275	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,611,494	$		$ 130,575	$	$ 1,196,552	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Allocated from Generations Healthcare Network, LLC	2009	34,824	939	39	893	(46)	8,073	3
4	Allocated from S.I.R. Properties/GHN	1993	63,055	2,002	35	1,802	(200)	45,939	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	15,986	445	20		(445)	15,986	9
10	Allocated from Generations Healthcare Network, LLC	1994	50		20			50	10
11	Allocated from Generations Healthcare Network, LLC	1995	365		20			365	11
12	Allocated from Generations Healthcare Network, LLC	1997	24,564	550	20		(550)	24,564	12
13	Allocated from Generations Healthcare Network, LLC	1999	1,931		20	97	97	1,858	13
14	Allocated from Generations Healthcare Network, LLC	1999	23,330		20			23,330	14
15	Allocated from Generations Healthcare Network, LLC	2000	2,280		20	114	114	2,114	15
16	Allocated from Generations Healthcare Network, LLC	2007	7,327		20	366	366	4,101	16
17	Allocated from Generations Healthcare Network, LLC	2008	20,193	388	20	747	359	13,276	17
18	Allocated from Generations Healthcare Network, LLC	2009	50,176	459	20	2,509	2,050	23,192	18
19	Allocated from Generations Healthcare Network, LLC	2011	1,241	124	20	124		921	19
20	Allocated from Generations Healthcare Network, LLC	2012	3,972	199	20	199		1,275	20
21	Allocated from Generations Healthcare Network, LLC	2014	557	56	20	28	(28)	128	21
22	Allocated from Generations Healthcare Network, LLC	2016	724	36	20	36		87	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	3,862	169	20	193	24	1,160	25
26	Allocated from S.I.R. Properties/GHN	2010	3,805		20	190	190	1,585	26
27	Allocated from S.I.R. Properties/GHN	2009	3,786		20	189	189	1,855	27
28	Allocated from S.I.R. Properties/GHN	2007	373	22	20	19	(3)	224	28
29	Allocated from S.I.R. Properties/GHN	2002	250		20	12	12	207	29
30	Allocated from S.I.R. Properties/GHN	1999	7,990		20	399	399	7,790	30
31	Allocated from S.I.R. Properties/GHN	1994	601	15	20		(15)	601	31
32	Allocated from S.I.R. Properties/GHN	1993	1,023	5	20		(5)	1,023	32
33									33
34	TOTAL (lines 1 thru 33)		$ 272,266	$ 5,408		$ 7,917	$ 2,508	$ 179,705	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 272,266	$ 5,408		$ 7,917	$ 2,508	$ 179,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 272,266	$ 5,408		$ 7,917	$ 2,508	$ 179,705	34

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 866,281	$ 4,872	$ 71,539	$ 66,667	10	$ 730,033	71
72	Current Year Purchases	5,350	112	495	383	10	495	72
73	Fully Depreciated Assets	1,275,342		924	924	10	1,275,342	73
74								74
75	TOTALS	$ 2,146,973	$ 4,984	$ 72,958	$ 67,975		$ 2,005,871	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 Generations Healtl	2018	$ 10,493	$ 661	$ 789	$ 128	5	$ 4,879	76
77										77
78										78
79										79
80	TOTALS			$ 10,493	$ 661	$ 789	$ 128		$ 4,879	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)	$ 16,982,582	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 535,411	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 356,316	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (179,095)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,980,787	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,309 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 Generations		$	$ 6,683	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,683	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

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):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Albany Care Inc # 0054262 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 88,277	$ 507,963	1
2	Cash-Patient Deposits	54,058	54,058	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,620,182	1,620,182	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,809	81,909	6
7	Other Prepaid Expenses	4,912	4,912	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	623	1,350,569	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,784,861	$ 3,619,593	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	3,498,517	6,047,260	15
16	Equipment, at Historical Cost	2,368,529	3,003,675	16
17	Accumulated Depreciation (book methods)	(4,163,152)	(12,111,028)	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): See Attached Schedule	396,949	522,445	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,100,843	$ 4,814,891	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,885,704	$ 8,434,484	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 395,353	$ 395,353	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	54,118	54,118	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	384,923	384,923	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,797	20,797	31
32	Accrued Real Estate Taxes(Sch.IX-B)		729,000	32
33	Accrued Interest Payable		99,977	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	5,000	5,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 860,191	$ 1,689,168	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		34,277,712	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		2,030,152	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 36,307,864	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 860,191	$ 37,997,032	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,025,513	$ (29,562,548)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,885,704	$ 8,434,484	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,096,542	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,096,542	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(71,029)	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	( )	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)**	$ (71,029)	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)**	$ 3,025,513	24	*

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

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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	$ 12,702,783	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,702,783	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***	82,956	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,956	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	44,093	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,093	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,829,832	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,278,883	31
32	Health Care	4,042,156	32
33	General Administration	3,096,193	33
	B. Capital Expense		
34	Ownership	3,423,629	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)***	$ 12,900,861	40
41	**Income before Income Taxes (line 30 minus line 40)****	(71,029)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (71,029)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,725,559	44
45	Private Pay - Net Inpatient Revenue	170,380	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Insurance	10,806,844	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,702,783	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.**

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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	1,879	2,086	$ 133,743	$ 64.11	1
2	Assistant Director of Nursing	1,294	1,412	42,896	30.38	2
3	Registered Nurses	3,558	3,782	126,828	33.53	3
4	Licensed Practical Nurses	31,034	33,365	908,078	27.22	4
5	CNAs & Orderlies	84,570	90,471	1,333,803	14.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,240	2,391	26,120	10.92	8
9	Activity Director					9
10	Activity Assistants	17,553	19,585	297,297	15.18	10
11	Social Service Workers	27,769	29,733	518,752	17.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,016	32,325	456,991	14.14	15
16	Dishwashers					16
17	Maintenance Workers	5,925	6,357	93,848	14.76	17
18	Housekeepers	24,168	26,738	333,994	12.49	18
19	Laundry					19
20	Administrator	1,827	2,086	164,752	78.98	20
21	Assistant Administrator	1,805	2,086	65,570	31.43	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,597	19,752	299,231	15.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,694	7,877	196,678	24.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	7,064	7,456	92,392	12.39	33
34	TOTAL (lines 1 - 33)	264,993	287,502	$ 5,090,973 *	$ 17.71	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	$ 53,844	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	100,080	10-03	38
39	Pharmacist Consultant	Monthly	36,346	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	Psychiatric MD	Monthly	7,200	12-03	47
48	Special Rehab	Monthly	80,064	10A-03	48
49	TOTAL (lines 35 - 48)		$ 277,534		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 56,395	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		10,341	10-03	52
53	TOTAL (lines 50 - 52)		$ 66,736		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Tossi	Administrator	3.12%	$ 164,752
Cynthia Schofield	Asst. Admin	0.00%	65,570
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 230,322

B. Administrative - Other

Description	Amount
SIR/Generations HN- Director of Admin. Services	$ 140,112
SIR/Generations HN- Consulting Fees	347,999
Director Fee- Michael Giannini	30,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 518,111
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR/Generations HN	Dir. Of Financial Services	$ 45,576
SIR/Generations HN	Dir. Of Regulatory Services	60,048
SIR/Generations HN	Dir. of Information Technology	30,024
SIR/Generations HN	Bookkeeping Fees	200,160
SIR/Generations HN	Computer Support Charges	65,052
SIR/Generations HN	Dir.of Marketing/Admissions	100,080
RSM	Accounting	1,950
Plante & Moran	Accounting	1,125
Marcum	Accounting	15,050
See Attached	Legal	11,393
Amari & Locallo	Real Estate Appeals	11,425
See Supplemental Schedule		25,031
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 566,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,525
Unemployment Compensation Insurance	26,555
FICA Taxes	379,175
Employee Health Insurance	264,335
Employee Meals	22,776
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	18,194
Life Insurance	3,087
401K Matching	5,750
Pension Plan Expense	47,739
TOTAL (agree to Schedule V, line 22, col.8)	$ 822,136

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	$ 1,896
Advertising: Employee Recruitment	3,674
Health Care Worker Background Check	
(Indicate # of checks performed 134)	1,340
Patient Background Checks 265	2,653
Dues & Subscriptions	28,503
Licenses and Permits	27,030
Allocated From Generations	221
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,881
Allocated From Generations	551
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,432

* Attach copy of IMRF notifications

**See instructions.

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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. $ **1,715** Line **10-2**

(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?
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. $ **22,776** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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? **100% Ln 14**
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? **N/A**
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? **N/A**
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