On the cover
The image on the cover and above at left is a normal brain positron emission tomography (PET) scan that shows no signs of Alzheimer’s disease. To its right is a brain scan showing mild Alzheimer’s. Red areas signify the highest concentration of beta-amyloid, one of the pathological hallmarks of the disease. Yellow and green areas show smaller, but still detectable, levels of beta-amyloid, and areas of dark blue signify where there is no beta-amyloid present.

The Alzheimer's Association is the leading donor-supported, voluntary health organization in Alzheimer research, care and support.

Our mission is to eliminate Alzheimer’s disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

Our vision is a world without Alzheimer’s.

Contact us at
www.alz.org
1.800.272.3900

alzheimer’s association
the compassion to care, the leadership to conquer
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message from Chair and President</td>
<td>2</td>
</tr>
<tr>
<td>Our role in research</td>
<td>6</td>
</tr>
<tr>
<td>Our role in care and support</td>
<td>16</td>
</tr>
<tr>
<td>Financial report</td>
<td>20</td>
</tr>
<tr>
<td>National Board of Directors</td>
<td>24</td>
</tr>
<tr>
<td>Medical and Scientific Advisory Council</td>
<td>25</td>
</tr>
<tr>
<td>Corporations, Foundations and Membership Organizations</td>
<td>25</td>
</tr>
<tr>
<td>Executive staff</td>
<td>25</td>
</tr>
<tr>
<td>Alzheimer's Association Organization</td>
<td>26</td>
</tr>
</tbody>
</table>

### How Alzheimer's Association 2006 expended funds were allocated

- **78%** of our funds were used for research grants; programs in Alzheimer care and support; awareness; and advocacy.
- **22%** of our funds were used for general management and fundraising.

The Alzheimer's Association is a nonprofit corporation exempt from federal income taxes under section 501(c)(3) of the Internal Revenue Code. The Association continues to meet and exceed minimum standards of 65 percent program expense set by the BBB Wise Giving Alliance.

©2007 Alzheimer's Association. All rights reserved.
As we mark our 26th year as the leading voluntary health organization in Alzheimer research and support, we reflect on the many strides made in the battle against Alzheimer’s disease. But we also look to the future and ready ourselves for the next wave of opportunities and challenges, because while progress brings great hope, it also brings new responsibilities.

Today we stand at a crossroads. An increasing aging population and advances in science, diagnostic tools and clinical therapies are changing the face of Alzheimer’s disease, and our organization must continue to respond and adapt as we lead the cause and engage others to act.

In 2006, the first of the 78 million baby boomers began turning 60. By 2030, when that entire generation will be over the age of 65, the number of Americans with Alzheimer’s is estimated to skyrocket to as many as 8 million and, by mid-century, could approach 16 million.

Meanwhile, up to 640,000 Americans live with early-onset Alzheimer’s and related dementias, which strikes people in their 30s, 40s and 50s. While the disease can be devastating to people of all ages, individuals with early-onset face a unique set of problems because most of the current programs and services – including financial relief – are geared toward an older population.

As an Association, our challenge is to meet both growing and changing needs with appropriate programs and services. Our goal is to continue to provide the best and most comprehensive information and support services – all day, every day – so that those living with Alzheimer’s get the assistance they need to manage the various phases of the disease. In 2006, we enlisted an advisory group of people living with early-stage Alzheimer’s to further inform our efforts.

We’re finding that people of all ages are being diagnosed at earlier stages of the disease than in the past due to increased awareness and provider knowledge, better approaches to assessment, and advances in diagnostic technologies. Researchers

As a nation, we can no longer afford to be apathetic about Alzheimer’s.
are making significant strides in disease-modifying drugs that could delay or slow progression and, as a result, within the next few years there may well be more people with the disease living longer at a functional level.

Together, these societal, scientific and clinical influences will have a profound impact on the Alzheimer population and require an updated and forward-looking response. Millions of Americans have the disease today, so we must renew our commitment to awareness and advocacy efforts and call again for funding that supports Alzheimer research.

As a nation, we can no longer afford to be apathetic about Alzheimer’s. Together, we must continue to press a national dialogue about this deadly disease. By talking about Alzheimer’s with friends and colleagues, you can help reduce the stigma that still surrounds it.

By writing letters, sending e-mails, attending rallies and participating in Association events, you can let your elected representatives and communities know this is an issue of great importance to you, one that warrants both their attention and research dollars.

The Alzheimer’s Association has been a catalyst behind nearly every major breakthrough and advance in Alzheimer research since 1982. By focusing on that progress in early detection, prevention and treatment of Alzheimer’s, we can ensure that the dialogue centers on hope through continued research and funding and the very real possibility of fulfilling our vision of a world without this disease.

In 2006, through a strategy of key partnerships, collaborations, grassroots efforts and Association-wide initiatives, we helped to improve care for affected individuals and to hasten scientific progress.

The Association has long played an important role in educating health care providers about best practices. In 2006, at the 14th Annual Dementia Care Conference, we released the second set of evidence-based Dementia Care Practice

The Association is playing a vital role in ensuring effective treatments are available as quickly as possible.

ON THE HORIZON
Major new insights are expected over the next 12 to 18 months as scientists continue to unravel the mystery of Alzheimer’s disease:

- We anticipate results from the first large-scale clinical trials of experimental drugs that may slow or stop progression of Alzheimer’s by targeting beta-amyloid.
- We will launch an Alzheimer’s Association Clinical Studies Initiative at five pilot sites nationwide.
- We will see the first eagerly anticipated data from the Alzheimer’s Disease Neuroimaging Initiative (ADNI), a very important, five-year effort to identify better ways to diagnose Alzheimer’s disease and monitor response to treatment, funded collaboratively by the federal government, industry and the Alzheimer’s Association.
Recommendations in the Alzheimer’s Association Campaign for Quality Residential Care, our multiyear initiative to improve the quality of care for people with dementia in assisted living residences and nursing homes.

Disease awareness and brain health education are important components of the Association’s mission, as we believe early intervention holds the eventual key to risk reduction. We are excited about our recent collaboration with the Centers for Disease Control and Prevention (CDC). Together with leaders in brain health research, the Association and the CDC are developing a national road map of recommended public health strategies to address brain health, and also developing a community intervention targeting the African-American population that is at risk for diabetes and high blood pressure, and may also be at greater risk for Alzheimer’s.

Last July, 5,000 researchers gathered in Madrid, Spain, for the biennial International Conference on Alzheimer’s Disease and Related Disorders (ICAD) that we convene, where the world’s leading scientists shared data on the pathology and treatment of Alzheimer’s disease and related dementias.

We also witnessed great progress in drug development policy this year. As a result of Association discussions with U.S. Food and Drug Administration (FDA) officials, the FDA has agreed to increase its commitment to fighting Alzheimer’s disease in several ways. It is creating a group of experts to better address issues related to the development of new treatments. The agency is also exploring strategies to expedite review of drugs for Alzheimer’s disease, and is moving to expand its existing drug review program to include people living with the disease and their caregivers as consultants.

Ultimately, the path to effective therapies is through clinical studies. At any given time, researchers are recruiting participants for hundreds of clinical studies to help explore new approaches. These studies need volunteers. In 2007, the Association will intensify its efforts to educate the public about the value of participation in clinical studies.
The promising initiatives on the horizon will take billions of dollars to fund, but that pales in comparison to the financial consequences we will experience without scientific progress.

In 2006, we faced a significant cut in federal funding for Alzheimer research and care programs. This was a wake-up call for all of us. Within just a decade, Medicare spending on people with Alzheimer’s disease will double to $189 billion annually; within 25 years, the Medicare system will spend as much on Alzheimer’s alone as it spends in total today.

Making Alzheimer’s disease a national priority isn’t just the socially responsible thing to do, it also is the fiscally responsible thing to do for our country.

We continue to urge Congress to appropriate at least $1 billion annually for large-scale Alzheimer research and clinical studies at the National Institutes of Health’s National Institute on Aging. Without adequate funding, the potential for a cure and ultimately for prevention will remain elusive.

This is just a snapshot of our 2006 achievements, but it reflects the steps we’re taking to better meet the needs of the changing Alzheimer population and to keep pace with the rapidly evolving field of Alzheimer care and research. The focus of this report is a perspective on our innovative, catalytic and convening role in Alzheimer science and care. Indeed, we are proud of the fact that without our organization’s contributions, what we know today about Alzheimer’s would not have been possible.

And while there is still much clinical and organizational work to be accomplished, we stand ready.

The exciting thing about any challenge is that it is also an opportunity. We believe we have an organization that can face and transcend the challenges so we can serve even more people who need us and can play the kind of leadership role in ending a disease that few organizations have the opportunity to do.

With the support of our loyal donors, dedicated volunteers and talented staff, we can have an even more dramatic and positive impact on caregivers, people living with Alzheimer’s disease today and on the disease itself tomorrow. Our work is aimed at fewer people being affected and, finally, at none being affected at all.

Making Alzheimer’s disease a national priority isn’t just the socially responsible thing to do, it also is the fiscally responsible thing to do for our country.
2007 marks the 25th year that the Alzheimer’s Association has funded research studies exploring disease characteristics, causes and possible therapies. Both our organization and the understanding we have of Alzheimer’s disease are still relatively young. In fact, most of our knowledge about Alzheimer’s – already the seventh-leading cause of death in the United States – has been gained in the past two decades, despite the first diagnosis being 100 years ago . . .

German physician Alois Alzheimer almost certainly had no inkling his 1901 consultation with a 51-year-old woman named Auguste would make medical history. Auguste had been admitted to the mental hospital where Dr. Alzheimer was a staff physician because her memory was failing and she often became lost in her own home. She carried household objects to odd places and was tormented by unfounded suspicions.

Dr. Alzheimer was mystified; nothing he offered Auguste seemed to improve her condition. Her health continued to decline, and she grew increasingly forgetful, confused and disabled. Within a few years she was bedridden. After Auguste’s death in spring 1906, Alzheimer performed an autopsy on her brain and saw dramatic shrinkage, dead brain cells and two kinds of microscopic deposits he’d never before observed.

At a scientific meeting in fall 1906, Dr. Alzheimer presented Auguste’s symptoms and brain abnormalities, and the newly discovered disorder soon entered medical literature as “Alzheimer’s disease.” The unusual deposits Dr. Alzheimer had observed became known as “plaques” and “tangles,” the key characteristics we identify today with Alzheimer’s disease.

In 1915, Dr. Alzheimer himself died, never suspecting that his encounter with Auguste would one day touch the lives of millions, drive an international research effort and provide the impetus for what is today the Alzheimer’s Association – the largest private nonprofit in Alzheimer research and the most enduring source of hope and support to those facing the disease.

Research shows...

It’s not normal aging.
These images show the neurons in a normal brain (top) and those affected by Alzheimer’s disease (bottom). Plaques and tangles, both telltale signs of the disease, are clearly visible and impede communication between individual nerve cells.

2007 marks the 25th year that the Alzheimer’s Association has funded research studies exploring disease characteristics, causes and possible therapies. Both our organization and the understanding we have of Alzheimer’s disease are still relatively young. In fact, most of our knowledge about Alzheimer’s – already the seventh-leading cause of death in the United States – has been gained in the past two decades, despite the first diagnosis being 100 years ago . . .

German physician Alois Alzheimer almost certainly had no inkling his 1901 consultation with a 51-year-old woman named Auguste would make medical history. Auguste had been admitted to the mental hospital where Dr. Alzheimer was a staff physician because her memory was failing and she often became lost in her own home. She carried household objects to odd places and was tormented by unfounded suspicions.

Dr. Alzheimer was mystified; nothing he offered Auguste seemed to improve her condition. Her health continued to decline, and she grew increasingly forgetful, confused and disabled. Within a few years she was bedridden. After Auguste’s death in spring 1906, Alzheimer performed an autopsy on her brain and saw dramatic shrinkage, dead brain cells and two kinds of microscopic deposits he’d never before observed.

At a scientific meeting in fall 1906, Dr. Alzheimer presented Auguste’s symptoms and brain abnormalities, and the newly discovered disorder soon entered medical literature as “Alzheimer’s disease.” The unusual deposits Dr. Alzheimer had observed became known as “plaques” and “tangles,” the key characteristics we identify today with Alzheimer’s disease.

In 1915, Dr. Alzheimer himself died, never suspecting that his encounter with Auguste would one day touch the lives of millions, drive an international research effort and provide the impetus for what is today the Alzheimer’s Association – the largest private nonprofit in Alzheimer research and the most enduring source of hope and support to those facing the disease.
In the first decades following Dr. Alzheimer’s initial observations, there was little progress in understanding the disease. Scientific debate centered on whether the symptoms and brain changes he had described were really signs of an illness or just normal effects of aging.

In the late 1950s, researchers began to make important discoveries, thanks to the newfound and unprecedented power of the electron microscope, as well as advances in molecular biology, which revealed the first hints about the nature of plaques and tangles. A consensus gradually emerged that Alzheimer’s was in fact a disease and not just a natural part of getting older or a result of unusually rapid aging.

Still, the disease remained a relatively low research priority until two defining events launched it onto the national health agenda. First, in 1974, Congress created the National Institute on Aging (NIA), a new agency with a mission to gain further insight into normal aging as well as Alzheimer’s disease and similar disorders.

“We don’t yet know where all Alzheimer’s starts, but we are absolutely, drop-dead, 100 percent certain that, in the cases where we do know, the disease begins with beta-amyloid.”

That’s the expert viewpoint of Sam Gandy, M.D., Ph.D., who has a string of impressive credentials following his name: director of the Farber Institute for Neurosciences at Thomas Jefferson University; professor of neurology, psychiatry and biochemistry at Jefferson Medical College; and, most importantly to the Alzheimer’s Association, chair of our national Medical and Scientific Advisory Council (MSAC), a panel of distinguished scientists and clinicians that advise on the Association’s research funding, programs and policy.

Dr. Gandy has been at the forefront of Alzheimer research since 1990, when he and his team discovered the first model drugs that could reduce beta-amyloid production in the brain. And recently, he has shown how hormones and statins can have the same beneficial effect.

“There are rare forms of Alzheimer’s that are caused directly by genes, in which we know exactly why and where the disease begins in the person’s brain,” says Dr. Gandy. “All of those cases involve inherited cellular mistakes that lead to beta-amyloid buildup. That doesn’t prove amyloid is the culprit in every case of Alzheimer’s, but it’s enough to put it at the top of the ‘most wanted molecule’ list for many scientists.”
Recognizing the pivotal role of scientific understanding and investigation, the Association quickly adopted research as one of its primary goals.

“Our current level of understanding could not have been achieved without support from the NIA and the Alzheimer’s Association. This knowledge now forms the basis from which future therapies aimed at modifying or even preventing Alzheimer pathology are being derived.”

—Richard C. Molts, Ph.D., Distinguished Research Fellow, Neuroscience Medical, Eli Lilly and Company

Soon after, in 1980, a small group of family caregivers, frustrated with medical indifference and a lack of information and support, founded the Alzheimer’s Association. From then on, those facing the disease, as well as those studying it, were backed by a support network that has become a robust and trusted resource for those living with Alzheimer’s disease.

Recognizing the pivotal role of scientific understanding and investigation, the Association quickly adopted research as one of its primary goals. To help strengthen this objective and shape the scientific agenda, in 1982 the organization launched its own peer-reviewed research grants program to accelerate insight into promising lines of inquiry, as well as to nurture ideas from talented researchers in the early stages of their careers. To date, this program has funded more than $200 million in scientific studies.

A number of early Association grants supported investigations of the cholinergic hypothesis, a dominant theory of the 1970s and 1980s named for the cell-to-cell messenger chemical acetylcholine. The hypothesis contended that the Alzheimer brain did not produce enough of this necessary substance and led the NIA and Warner Lambert Pharmaceutical Co. to launch a large clinical trial of tacrine, the first experimental drug based on the theory. They immediately turned to the Alzheimer’s Association to assist in the recruitment of study participants.

As a result of this collaboration, tacrine became the first drug approved by the U.S. Food and Drug Administration (FDA) specifically to treat symptoms of Alzheimer’s disease. The agency later approved three additional drugs based

Research shows...

African-Americans and Hispanics are at increased risk for diabetes and high blood pressure, and may also be at greater risk for Alzheimer’s. Our community-based education programs, publications and Web sites reach out to these and other diverse populations.
on the same chemical principle: donepezil (Aricept®), rivastigmine (Exelon®) and galantamine (Razadyne®). Today these drugs, called cholinesterase inhibitors, remain a core treatment for Alzheimer symptoms.

Data and clinical experience have since shown that while cholinesterase inhibitors temporarily delay worsening of symptoms for some people, there is no currently approved drug that can stop the death of cells in the Alzheimer brain. Still, demonstrating that Alzheimer’s could be treated at all was a landmark step in raising the visibility of the disease, attracting more researchers to the cause and inspiring efforts to develop better therapies.

As a result of the Association’s pledge to nurture ideas, researchers were already moving forward in new directions even as work on the cholinergic hypothesis dominated the field.

In 1983, the Association awarded the first of several grants to Harvard researcher Dennis J. Selkoe, M.D. Selkoe suspected the answer to Alzheimer’s disease lay in the biological processes leading to the development of plaques and 

At the time of the Alzheimer’s Association founding in 1980, Alzheimer research was given an inadequate $13 million in federal funding. Annual government funding in 2006 was $652 million, an accomplishment directly attributable to the Association’s grassroots advocates, public policy team and the resolute support of two congressional champions: Senators Tom Harkin (D-Iowa) and Arlen Specter (R-Pa.).

Since the opening of our Washington, D.C., public policy office in 1989, Sens. Harkin and Specter have worked closely with our team to deliver key support for Alzheimer research. As chairman and ranking member, respectively, of the U.S. Senate Labor, Health and Human Services and Education Appropriations Subcommittee, they hold stewardship over the nation’s premier research agency, the National Institutes of Health (NIH).

Under their leadership, federal research funding has steadily increased. Between 1998 and 2003, they led a campaign to double funding for the NIH, an effort that boosted annual spending on Alzheimer research by $302 million. This support has furthered the research of thousands of independent scientists, as well as a network of 32 Alzheimer’s Disease Research Centers (ADRCs) under the leadership of the National Institute on Aging (NIA).

Their partnership is also responsible for securing resources for the Centers for Disease Control (CDC) healthy brain initiative, the Alzheimer’s Association 24/7 Helpline and the Alzheimer’s Disease State Matching Grants Program, which provides funds to states for community-based Alzheimer services.

Thanks to their long-standing partnership and vital support, the Alzheimer’s Association has promoted critical research and provided continued hope for millions of Americans living with the disease.
Demonstrating that Alzheimer’s could be treated was a landmark step in raising the visibility of the disease, attracting more researchers to the cause and inspiring efforts to develop better therapies.

“Receiving my first grant from the Alzheimer’s Association was a very big step toward getting NIH funding for this work, and it made a real difference in my progress. I am most grateful for the wonderful scientific interactions with the Association throughout my career.”

*Dennis J. Selkoe, M.D., Harvard University*

tangles – the original signs of the disease observed and described by Dr. Alzheimer. Selkoe soon emerged as one of the leading contributors to the **amyloid hypothesis**, the theory that plaque formation is one of the key chemical processes responsible for Alzheimer’s disease.

During the late 1980s and early 1990s, a series of discoveries lent considerable weight to the amyloid hypothesis, as scientists:

- Identified a protein fragment called **beta-amyloid** as the chief component of plaques.
- Traced the origin of beta-amyloid to a parent protein called **amyloid precursor protein (APP)** found in cells throughout the brain.
- Found that beta-amyloid interferes with the brain’s cell-to-cell communication, thereby impeding memory, language, thought, judgment and other cognitive functions.
- Established that plaques found in Alzheimer’s disease and in older adults with Down syndrome are chemically identical.
- Determined that the gene carrying the APP “blueprint” lies on chromosome 21. An extra copy of chromosome 21 is the distinguishing feature of Down syndrome.
- Discovered within the APP gene the first mutation linked to a rare, inherited form of Alzheimer’s disease.
- Demonstrated the existence of potential pharmaceutical compounds that could shift processing of APP away from production of beta-amyloid toward other harmless fragments.

As evidence for the amyloid hypothesis fueled further investigation, Association-supported scientists continued to make key discoveries in other areas. A 1993 Zenith Fellows award to
Alison Goate, Ph.D., supported work that led to identification of a gene mutation on chromosome 14, which was responsible for another inherited form of Alzheimer’s.

Also in 1993, an Alzheimer’s Association grant to Karen Hsiao Ashe, M.D., Ph.D., supported the groundwork to develop the first mice genetically capable of producing human beta-amyloid. As they aged, the mice developed problems remembering their way through mazes.

And, in 1995, an Alzheimer’s Association grant supported the efforts of William Klunk, M.D., Ph.D., and Chester Mathis, Ph.D., to develop substances capable of detecting beta-amyloid in the living brain.

Kluck’s efforts gradually focused on methoxy-X04, an experimental compound that his team shared with Bradley T. Hyman, M.D., Ph.D. Hyman, who was working on a technique to allow scientists to directly observe the brain in living mice, received an Alzheimer’s Association $1 million Pioneer Award to further his work.

Mary Siegel, left, with Zenith members Linda and Bob Mendelson, at a recent Zenith event, are vital contributors to our mission.

For 16 years, a group of highly committed donors has led the way in giving at the Alzheimer’s Association. The Zenith Program has brought together top philanthropists – those giving $1 million or more – to play an active and engaged role in leading key research and care projects.

Beginning with research, this group has focused on developing the field’s top scientific leaders and advancing innovative concepts. Donors at this level have also changed the landscape for how the Association provides support for families across the country, ranging from the creation of a national Alzheimer library to elevating the community-based care consultation and educational programs of our chapters.

Jerome H. Stone, founder and honorary chairman of the Association, established the Zenith Program in 1990, bringing together individuals from around the country who have been touched deeply by Alzheimer’s disease – and who have the means to help us find a cure. The Zenith Program attempts to harness the collective power and influence of these private citizens and organizations by partnering with the Association to invest in strategic ways to change the course of Alzheimer’s and to better serve families and individuals living with the disease.

The remarkable dedication of Zenith members has resulted in more than $40 million donated to the Alzheimer field, supporting efforts that are advancing research, improving care and raising awareness of brain health.
As work on methoxy-X04 progressed in mice, Klunk received additional Association funding for a project that aimed to optimize a new compound for human studies by focusing on its ability to pass from the bloodstream into brain tissue and its capacity to adhere to beta-amyloid.

After extensive preliminary testing by Klunk’s Pittsburgh team, this new compound became known as Pittsburgh compound B (PIB). PIB was first tested in human volunteers through an international collaboration of Klunk’s team and colleagues in Uppsala, Sweden.

Results of these first small human studies indicated that PIB shows the levels of beta-amyloid present in the brain by latching onto the beta-amyloid and “lighting up” in a positron emission tomography (PET) scan. These groundbreaking results were reported in Stockholm in 2002 at the Alzheimer’s Association International Conference on Alzheimer’s Disease and Related Disorders (ICAD). Ongoing PIB data continued to look so promising that a February 2005 Archives of Neurology report cited PIB as a “model of progress” toward imaging abnormal brain deposits linked to specific diseases.

Finding methods of early intervention and prevention will depend on developing the ability to detect the earliest brain changes associated with Alzheimer’s disease, and PIB-PET could help meet this need. As part of its 2006 research funding, the Alzheimer’s Association committed $2.1 million, its largest single award, to add a PIB-PET investigation to the Alzheimer’s Disease Neuroimaging Initiative (ADNI). ADNI is a five-year, nationwide study with lead funding from the NIA, and additional

Research shows...
Clinical studies are the only path to better diagnostics, drugs and other treatments that can slow or stop the disease. Find out how to join a study by calling us at 1.800.272.3900.

As evidence for the amyloid hypothesis fueled further investigation, Association-supported scientists continued to make key discoveries . . .

“Had the Alzheimer’s Association not been willing to fund our early, high-risk, high-potential exploration of PIB and its precursors, this work might not have reached fruition. Now, more than ever, this is the kind of progressive research that needs Association support as the next generation of researchers pursues additional possibilities.”

William E. Klunk, Ph.D., University of Pittsburgh Medical Center
More than 5,000 of the brightest minds in Alzheimer research came to Madrid, Spain, in July 2006 to attend the International Conference on Alzheimer’s Disease and Related Disorders (ICAD) and debate the latest discoveries on the etiology, pathology and treatment of Alzheimer’s.

Each day of the five-day conference, hosted by the Alzheimer’s Association, saw fresh, compelling data emerge, including the most recent findings on the connection between Type 2 diabetes and Alzheimer’s; state-of-the-art imaging techniques; cutting-edge pharmaceutical therapies; and early detection technology. Researchers presented a record-high 2,000 scientific abstracts.

ICAD drew media from around the world, making front-page news in Europe and America and resulting in hundreds of print, broadcast and radio placements. More than 142 million media impressions helped spread awareness of Alzheimer’s disease, science and the important role the Association plays in convening this prestigious assembly.

To extend the energy of ICAD further into the field of early intervention and diagnostics, the Alzheimer’s Association International Conference on Prevention of Dementia convenes in June 2007 in Washington, D.C., to host some 1,500 researchers, physicians and policy advocates focused on dementia prevention, risk and intervention.
For the past quarter century we have helped to improve the lives of millions, which would not have been possible without thousands of dedicated donors, volunteers, advocates and research partners.

funding from the pharmaceutical industry and the Alzheimer’s Association. Without our support of this important initiative, the PIB–PET extension of ADNI would have gone unfunded.

One goal of the ADNI study is to standardize brain imaging procedures, ensuring that images obtained by different researchers at various locations will capture the same medical and scientific information. Further goals are to determine whether imaging, possibly in combination with laboratory and psychological tests, can offer a way to detect the earliest signs of Alzheimer’s, track disease progression and monitor response to treatment.

The study has the potential to clarify the role of beta-amyloid in both the pathology and symptoms of Alzheimer’s disease. Two critical questions are facing the field today: Is the beta-amyloid hypothesis correct, and will beta-amyloid-targeting drugs be a part of the solution to eliminating Alzheimer’s?

If beta-amyloid is a key part of the answer to understanding the pathology of Alzheimer’s, we need to intensify our efforts to understand its effects, identify the most toxic steps leading to its production and refine our therapeutic strategies. If beta-amyloid is not the answer, we need to move quickly down other paths to success.

Projects currently receiving Association funding that examine disease mechanisms other than beta-amyloid include:

- Strategies to maintain brain health and stave off memory loss, including lifestyle choices, nerve growth factors and dietary supplements.

Research shows...
Lifestyle may affect your brain health and risk for dementia. Our nationwide chapter staff present Maintain Your Brain® workshops in hundreds of communities each year.
• Investigation of the relationship between diseases of the heart and blood vessels and Alzheimer’s disease. Growing evidence suggests that Alzheimer’s and coexisting vascular brain disease, another widespread health condition, become increasingly common with advancing age. These two disease processes may interact in important ways to increase the likelihood of cognitive decline.

• Studies focusing on tau, the protein that undergoes abnormal chemical processes to form tangles, the other hallmark Alzheimer brain abnormality.

• The strengthening of the connection between Alzheimer’s disease, Type 2 diabetes and insulin resistance. Factors affecting brain cells’ ability to use glucose and generate energy may play an important role in cognitive decline.

There has never been a more exciting time in Alzheimer research – and our mission has never been so urgent. We are at a crossroads in the investigation of a disease that touches lives around the world and will continue to wreak havoc on the global population if we do not continue moving forward with the momentum we have built.

For the past quarter century we have helped to improve the lives of millions, which simply would not have been possible without our thousands of donors, volunteers, advocates and research partners. Now, more than ever, your support is critical.

Scientists learn about the effectiveness of potential Alzheimer treatments by studying outcomes of volunteers in clinical trials. To sustain the current pace of discovery, the Alzheimer’s Association launched a Clinical Studies Initiative in 2006 to identify and surmount the barriers to research participation and to encourage recruitment of more study volunteers.

Clinical studies play an enormous role in helping us learn which therapies may effectively treat Alzheimer’s, and while there are a number of promising therapeutic targets currently in development and testing phases, difficulty recruiting volunteers for studies is a major roadblock to progress.

To learn more about how you can volunteer for a clinical study, call 1.800.272.3900 or visit www.alz.org. We link directly to ClinicalTrials.gov, the medical research database hosted by the National Institutes of Health (NIH), which lists more than 100 clinical studies currently recruiting participants with dementia.
Being a catalyst for Alzheimer research is only one part of our mission. The Alzheimer’s Association has been the leader in improving dementia care access and quality since our organization was founded by a few family caregivers who could not find the resources they needed to cope with the disease. Today, we provide some 300 points of local service nationwide – an unequaled network of support services for those seeking Alzheimer information, support and care.

Research shows...
Family caregivers who attend support groups and receive regular check-in telephone calls report a better quality of life and lower rate of depression, according to a recent study (Resources for Enhancing Alzheimer’s Caregiver Health II). Our facilitated support groups, 24/7 Helpline and online message boards provide caregivers ways to connect and get professional support all day, every day.

1.800.272.3900

Being diagnosed with Alzheimer’s doesn’t just transform the life of the individual with the disease – it profoundly affects the person’s family, friends, co-workers and loved ones. In 2006, more of them turned to us for compassion, care and hope for a cure than ever before. In addition, increased public interest – fueled by national media coverage, research breakthroughs and an aging population concerned about sustaining wellness – drove millions to seek our information and education services.

Alzheimer’s disease can be puzzling, frightening and overwhelming. By offering a diverse selection of community-based services through our chapters nationwide, we help alleviate these concerns by connecting people to us, to local resources and to each other.

Master’s-level clinicians provided more than 80,000 one-to-one care consultations last year. Our 24/7 Helpline staff fielded 255,000 calls from people seeking information about Alzheimer’s disease. On-call consultants provided guidance, information and support, partnering with a translation center to offer counsel in more than 140 languages and dialects.

Whether by phone, fax, e-mail, Web or face-to-face, compassionate support and guidance were readily accessible for families coping with Alzheimer’s disease. We helped them assess the needs of individuals with dementia; provided educational materials; suggested additional care strategies; and offered tips on behavior, communication and how to better understand the disease process.

www.alz.org   1.800.272.3900
Our Web site, www.alz.org, was a reliable source of information for more than 6 million visitors during the year, including people living with the disease, caregivers, researchers, health care providers, advocates and the general public. And, in addition to providing news, facts, activities and ways to get involved, the site hosts a number of highly trafficked message boards that serve as secure, virtual support groups for those seeking to connect with others who are managing the disease.

Last year we also grew our extensive portfolio of informational materials to include a new suite of publications especially for African-American audiences. Because these constituents may be at greater risk for Alzheimer’s disease, the Association developed four publications specifically for African-Americans to explain warning signs of the disease, caregiver stress and brain health, as well as an extensive pastoral care guide for clergy.

Among our hallmark care offerings are facilitated, multilingual support groups – hosted in multiple locations in local communities nationwide – where persons with the disease, Is it Alzheimer’s or just signs of aging? 10 signs every African-American should know Keeping your mind sharp Brain health and African-Americans Staying strong Stress relief for the African-American caregiver Lighting the path for people affected by Alzheimer’s African-American clergy guide

“I called the Alzheimer’s Association yesterday about the care of my mother and father. The woman I spoke to was incredibly knowledgeable and gave me some great information, but I was most impressed with her caring, compassionate and professional manner. I felt like I was speaking to a smart, close relative. Thank you. It’s comforting to know an answer is just a phone call away.”

Help and hope are as near as your telephone, computer or local community office when you connect with one of the thousands of dedicated volunteers and professional staff members in Alzheimer’s Association chapters across the country.

As our front line of community-based care, chapters offer a spectrum of services for those living with Alzheimer’s, families and caregivers. These include Web sites, a toll-free telephone and e-mail helpline, support groups, individual care consultations, respite care, educational workshops, classroom and online training, free publications and referrals to local health care resources.

Chapters also help build greater awareness and understanding of the disease by hosting special events in their communities such as Memory Walk®, an annual fundraiser open to all ages.

To connect with an Alzheimer’s Association office near you, visit www.alz.org or call 1.800.272.3900.
Research shows...
Six million visitors to www.alz.org in 2006 visited these sections often to find information and assistance:
• Inside the Brain: An Interactive Tour
• CareFinder™
• What is Alzheimer’s disease?
• Ten warning signs of Alzheimer’s disease
• Living with Alzheimer’s
• Chat rooms and message boards
• Maintain Your Brain®

See for yourself: Visit us online today.

caregivers and direct care providers can come together to share experiences and learn from each other. In 2006, more than 300,000 participants – including those living with early-onset and early-stage Alzheimer’s – helped each other through a variety of issues.

Safety is a daily concern for anyone coping with Alzheimer’s. Six in 10 people with dementia will develop wandering behavior and are at risk for becoming lost. Alzheimer’s Association Safe Return® is a nationwide identification and registry program that provides assistance when a person with Alzheimer’s or a related dementia wanders and becomes lost. In 2006, 16,300 people with dementia were enrolled in Safe Return, a 15 percent increase from 2005. And during the year, our staff facilitated the return of 1,240 people who wandered.

Local education programs continued to be one of our main pillars of support in 2006, with more than 250,000 constituents taking advantage of the educational workshops and seminars we offer.

Maintain Your Brain®, our campaign promoting lifestyle changes related to brain health, taught easy, enjoyable ways to exercise minds and bodies. Memories in the Making inspired creativity and memory recollection in persons with dementia through engaging art therapy. And, Partnering with Your Doctor provided people living with Alzheimer’s and their families better techniques for communicating and building relationships with their physicians.

Our commitment to education extends to professional health care providers though our Campaign for Quality Residential Care, now in its second year. This national effort builds on our leadership in dementia care by bringing together key care advocates to support dementia care recommendations, education and ongoing collaboration.

Our campaign goal is to improve the quality of life for those with dementia by raising the standard of how health care
CareFinder™, our interactive, online program for those seeking quality home and residential care services, was launched in 2006 and, in its first six months, helped 94,000 Web visitors make informed decisions about care.

Based on the person-centered care philosophy that underlies our quality care campaign, CareFinder leads users through a menu of various questions and choices to evaluate capabilities, needs and personal preferences and guides them in creating an individualized plan for home, assisted living or nursing home care.

Key components of our campaign are classroom and online training programs that put our recommendations into daily practice. As we develop additional care recommendations, we are creating new modules for our Foundations of Dementia Care training for supervisors and direct care workers in long-term care settings.

Over the past two years we have developed a grassroots movement to encourage federal and state policy-makers to champion our care recommendations. In 2006, Association chapters in 27 states participated in our quality care campaign to address public policy issues in long-term care.

CareFinder offers ways to communicate effectively with providers of direct care services and includes information on how to pay for care and find local community resources.

The basis of the campaign is our report, Dementia Care Practice Recommendations, supported by 28 major health and senior care organizations. Based on the latest research and evidence from experts in the field and, we announced Phase II of these recommendations at our annual Dementia Care Conference in September 2006.

This phase covers recommendations for preventing unhealthy wandering and falling and for providing care that is free of physical restraints. Phase I addressed food and fluid needs, pain management and the importance of social engagement for people with dementia. The next phase of recommendations – focusing on end-of-life issues – will be released at the Dementia Care Conference in August 2007.

Key components of our campaign are classroom and online training programs that put our recommendations into daily practice. As we develop additional care recommendations, we are creating new modules for our Foundations of Dementia Care training for supervisors and direct care workers in long-term care settings.

Advocacy, research, education, care and support sustain our mission – and drive us closer every day to achieving our vision of a world without Alzheimer’s.
The financial health of the Alzheimer’s Association improved significantly in fiscal year 2006 with the national organization recording total assets of over $124 million, an increase of 13 percent compared to fiscal year 2005 assets of $110 million.

Total revenues of $85.1 million increased slightly from 2005, of which $73.9 million came from donor contributions as more people joined us in the fight against Alzheimer’s disease. Together with our network of 79 affiliated chapters, unaudited revenues totaled nearly $206 million.

Expenses were well managed by the national organization, allowing us to maintain our program spending ratios from 2005. With our chapters, the combined Alzheimer’s Association expended over $141 million on program activities to move our mission forward.

To advance progress in Alzheimer science, we invested almost $25 million in research, the largest annual amount in our history. As the largest funding resource after the U.S. government and the pharmaceutical industry, we strive to increase our research funding each year to achieve our vision of a world without Alzheimer’s.

The Association continues to meet and exceed minimum standards of 65 percent program expenses set by the BBB Wise Giving Alliance. We are at 78 percent.

We are honored and grateful that our donors respect our stewardship, embrace our mission and are a vital part of the movement to conquer Alzheimer’s disease.

Michael Urbut, CPA
Treasurer, National Board of Directors

---

National Alzheimer’s Association audited statements of activities

- **TOTAL 2006 REVENUE** $85.1 MILLION
  - Contributed 87%
  - Non-contributed 13%

- **TOTAL 2006 EXPENSES** $72.3 MILLION
  - Advocacy, awareness and support 36%
  - Research 35%
  - Administration/fundraising 22%
  - Support for chapters 7%
### Consolidated statements of financial position

For the year ended June 30, 2006  
(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$6,841</td>
<td>$4,834</td>
</tr>
<tr>
<td>Chapter dues receivable, less allowances for uncollectible amounts</td>
<td>1,505</td>
<td>1,564</td>
</tr>
<tr>
<td>($472 in 2006 and $568 in 2005)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pledges receivable, less allowances for uncollectible amounts</td>
<td>23,188</td>
<td>26,055</td>
</tr>
<tr>
<td>($2,033 in 2006 and $2,572 in 2005)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint venture pledges and receivables</td>
<td>4,426</td>
<td>5,646</td>
</tr>
<tr>
<td>Other receivables</td>
<td>619</td>
<td>514</td>
</tr>
<tr>
<td>Inventories of education materials, at cost</td>
<td>388</td>
<td>337</td>
</tr>
<tr>
<td>Investments</td>
<td>68,958</td>
<td>56,724</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>4,424</td>
<td>1,604</td>
</tr>
<tr>
<td>Furniture, equipment and leasehold improvements, at cost</td>
<td>12,470</td>
<td>10,748</td>
</tr>
<tr>
<td>Less accumulated depreciation</td>
<td>(6,915)</td>
<td>(5,577)</td>
</tr>
<tr>
<td>Beneficial interest in perpetual trust</td>
<td>8,746</td>
<td>7,993</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>$124,650</td>
<td>$110,442</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Liabilities and net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$1,401</td>
<td>$1,377</td>
</tr>
<tr>
<td>Grants payable</td>
<td>37,351</td>
<td>34,781</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>2,956</td>
<td>4,217</td>
</tr>
<tr>
<td>Joint venture obligations</td>
<td>3,117</td>
<td>3,376</td>
</tr>
<tr>
<td>Gift annuity obligations</td>
<td>4,812</td>
<td>3,914</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>3,019</td>
<td>1,17</td>
</tr>
<tr>
<td>Deferred rent</td>
<td>3,154</td>
<td>3,334</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td>55,810</td>
<td>51,136</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>32,019</td>
<td>24,840</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>18,593</td>
<td>17,086</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>18,228</td>
<td>17,380</td>
</tr>
<tr>
<td><strong>TOTAL NET ASSETS</strong></td>
<td>68,840</td>
<td>59,306</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td>$124,650</td>
<td>$110,442</td>
</tr>
</tbody>
</table>
### Consolidated statements of activities

For the year ended June 30, 2006
(in thousands)

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted</th>
<th>Temporarily Restricted</th>
<th>Permanently Restricted</th>
<th>2006 Total</th>
<th>2005 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues, gains and other support:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>$50,809</td>
<td>$22,345</td>
<td>$732</td>
<td>$73,886</td>
<td>$69,779</td>
</tr>
<tr>
<td>Chapter dues</td>
<td>6,340</td>
<td>–</td>
<td>–</td>
<td>6,340</td>
<td>5,704</td>
</tr>
<tr>
<td>Book sales and other</td>
<td>2,669</td>
<td>2</td>
<td>–</td>
<td>2,671</td>
<td>7,130</td>
</tr>
<tr>
<td>Dividends and interest</td>
<td>1,750</td>
<td>487</td>
<td>–</td>
<td>2,237</td>
<td>1,690</td>
</tr>
<tr>
<td>Net assets released from restriction</td>
<td>21,739</td>
<td>(21,739)</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>TOTAL REVENUES, GAINS AND OTHER SUPPORT</strong></td>
<td>83,307</td>
<td>1,096</td>
<td>732</td>
<td>85,134</td>
<td>84,303</td>
</tr>
</tbody>
</table>

| **Expenses:** |              |                        |                        |            |            |
| PROGRAM SERVICES: |              |                        |                        |            |            |
| Research          | 24,991       | –                      | –                      | 24,991     | 24,551     |
| Public awareness and education | 16,101 | –                      | –                      | 16,101     | 17,973     |
| Chapter services  | 5,338        | –                      | –                      | 5,338      | 5,743      |
| Public policy     | 3,081        | –                      | –                      | 3,081      | 2,845      |
| Patient and family services | 7,139 | –                      | –                      | 7,139      | 6,658      |
| **TOTAL PROGRAM SERVICES** | 56,650 | – | – | 56,650 | 57,770 |

| SUPPORTING SERVICES: |              |                        |                        |            |            |
| Management and general | 626     | –                      | –                      | 626        | 640        |
| Fundraising           | 15,008      | –                      | –                      | 15,008     | 15,372     |
| **TOTAL SUPPORTING SERVICES** | 15,634 | – | – | 15,634 | 16,012 |
| **TOTAL EXPENSES**    | 72,284      | –                      | –                      | 72,284     | 73,782     |
| Income from operations | 11,023     | 1,095                  | 732                    | 12,850     | 10,521     |
| Transfer of revenues  |              |                        |                        |            |            |
| to Chapter/Joint Venture Partners | (4,305) | –                      | –                      | (4,305)    | (4,500)    |
| **Net realized and change in unrealized gains** |            |                        |                        |            |            |
| (losses) in value of investments | 965       | 225                    | –                      | 1,190      | 1,963      |
| Change in value of split-interest agreement | (504) | 187                    | –                      | (317)      | –          |
| Change in value of perpetual trust | –          | –                      | 116                    | 116        | 200        |
| **INCREASE IN NET ASSETS** | 7,179 | 1,507 | 848 | 9,534 | 8,184 |
| **NET ASSETS AT BEGINNING OF YEAR** | 24,840 | 17,086 | 17,380 | 59,306 | 51,122 |
| **NET ASSETS AT END OF YEAR** | $32,019 | $18,593 | $18,228 | $68,840 | $59,306 |
# National and Chapter Combined Revenue and Expense Statements

For the year ended June 30, 2006  
(in thousands)

<table>
<thead>
<tr>
<th>(Unaudited)</th>
<th>National</th>
<th>Chapters</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues, gains and other support:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>$73,886</td>
<td>$98,262</td>
<td>($4,913)</td>
<td>$167,235</td>
</tr>
<tr>
<td>Chapter dues</td>
<td>6,340</td>
<td>–</td>
<td>(6,340)</td>
<td>–</td>
</tr>
<tr>
<td>Book sales and other</td>
<td>2,671</td>
<td>26,444</td>
<td>(824)</td>
<td>28,291</td>
</tr>
<tr>
<td>Dividends and interest</td>
<td>2,237</td>
<td>7,863</td>
<td>–</td>
<td>10,100</td>
</tr>
<tr>
<td><strong>TOTAL REVENUES, GAINS AND OTHER SUPPORT</strong></td>
<td>85,134</td>
<td>132,569</td>
<td>(12,077)</td>
<td>205,626</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PROGRAM SERVICES:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>24,991</td>
<td>–</td>
<td>–</td>
<td>24,991</td>
</tr>
<tr>
<td>Public awareness and education</td>
<td>16,101</td>
<td>–</td>
<td>–</td>
<td>16,101</td>
</tr>
<tr>
<td>Chapter services</td>
<td>5,338</td>
<td>–</td>
<td>–</td>
<td>5,338</td>
</tr>
<tr>
<td>Public policy</td>
<td>3,081</td>
<td>–</td>
<td>–</td>
<td>3,081</td>
</tr>
<tr>
<td>Patient and family services</td>
<td>7,139</td>
<td>92,454</td>
<td>(7,772)</td>
<td>91,821</td>
</tr>
<tr>
<td><strong>TOTAL PROGRAM SERVICES</strong></td>
<td>56,650</td>
<td>92,454</td>
<td>(7,772)</td>
<td>141,332</td>
</tr>
<tr>
<td><strong>SUPPORTING SERVICES:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management and general</td>
<td>626</td>
<td>12,328</td>
<td>–</td>
<td>12,954</td>
</tr>
<tr>
<td>Fundraising</td>
<td>15,008</td>
<td>18,490</td>
<td>–</td>
<td>33,498</td>
</tr>
<tr>
<td><strong>TOTAL SUPPORTING SERVICES</strong></td>
<td>15,634</td>
<td>30,818</td>
<td>–</td>
<td>46,452</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>72,284</td>
<td>123,272</td>
<td>(7,772)</td>
<td>187,784</td>
</tr>
<tr>
<td>Income from operations</td>
<td>12,850</td>
<td>9,297</td>
<td>(4,305)</td>
<td>17,842</td>
</tr>
<tr>
<td>Transfer of revenues to Chapter/Joint Venture Partners</td>
<td>(4,305)</td>
<td>–</td>
<td>4,305</td>
<td>–</td>
</tr>
<tr>
<td>Net realized and change in unrealized gains</td>
<td>1,190</td>
<td>–</td>
<td>–</td>
<td>1,190</td>
</tr>
<tr>
<td>(losses) in value of investments</td>
<td>(317)</td>
<td>–</td>
<td>–</td>
<td>(317)</td>
</tr>
<tr>
<td>Change in value of split-interest agreement</td>
<td>116</td>
<td>–</td>
<td>–</td>
<td>116</td>
</tr>
<tr>
<td><strong>INCREASE IN NET ASSETS</strong></td>
<td>$ 9,534</td>
<td>$ 9,297</td>
<td>$ –</td>
<td>$ 18,831</td>
</tr>
</tbody>
</table>

---

**The Combined Revenue and Expense Statements**

Combined Revenue and Expense Statements are unaudited and not part of the Alzheimer’s Association audited financial statements.

June 30, 2006

1. **Compilation Policy:** The combined financial information for the 12 months ended June 30, 2006, was compiled from reports provided to the national office by the Association’s 79 chapters and combined with the audited activity of the national office for the 12 months ended June 30, 2006. The unaudited quarterly reports submitted by the chapters summarized the revenue and expense activity of the individually incorporated chapters and were compiled into a combined report for management reporting purposes. The accounting policies followed by the chapters are not necessarily the same practices followed by the national office.

2. **Eliminations:** All material intercompany transactions were eliminated in this combined statement.
Members of our national board of directors serve multiyear terms and are volunteers who feel passionately about our mission. They generously support our efforts in research, care and advocacy with their time, talent and contributions.

**Chair**
Lawrence Varnes
Glendale, Calif.

**Chair Elect**
Evan Thompson
Beverly Hills, Calif.

**Honorary Chairman**
Jerome H. Stone
Chicago, Ill.

**Honorary Vice Chair**
Princess Yasmin Aga Khan
New York, N.Y.

**Vice Chairs**
Samuel E. Gandy, M.D., Ph.D.

Diane Bazalides
Houston, Texas

Mark E. Flynn
Chicago, Ill.

William Kaye
New York, N.Y.

Robert D. Thomas
Tulsa, Okla.

Robert A. Wooldridge
Dallas, Texas

**Secretary**
Paul Attea
Hyannis, Mass.

**Treasurer**
Michael Urbut, CPA
Naperville, Ill.

**Directors**
Marilyn S. Albert, Ph.D.
Baltimore, Md.

Michael Arthur
Los Angeles, Calif.

Mary Guerriero Austrom, Ph.D.
Indianapolis, Ind.

Edward Berube
Essex, Conn.

Patricia Lanoie Blanchette, M.D., M.P.H.
Honolulu, Hawaii

R. Thomas Bodkin
Evansville, Ind.

Lane Bowen
Louisville, Ky.

Gwendolyn Boyd
Laurel, Md.

Christine Fears Branche
Cleveland, Ohio

Randolph Brock III
St. Albans, Vt.

Heather Burns
McLean, Va.

Charles M. Cole III
Tulsa, Okla.

Laurel Coleman, M.D.
Manchester, Maine

George S. Conklin
Houston, Texas

David Dealy III
Fort Worth, Texas

Steven T. DeKosky, M.D.
Pittsburgh, Pa.

Richard Della Penna, M.D.
San Diego, Calif.

Peggye Dilworth-Anderson, Ph.D.
Chapel Hill, N.C.

Cathy Edge
Caledonia, Ill.

Shelley Fabares
Sherman Oaks, Calif.

Michael Fuchs
New York, N.Y.

Marshall Gelfand, CPA
Los Angeles, Calif.

Colleen Goldhammer
Richmond, Va.

Larry Joddaas
St. Paul, Minn.

Karen Kauffman, Ph.D., C.R.N.P., B.C.
Baltimore, Md.

John Maggio, Ph.D.
Cincinnati, Ohio

Jennifer Manly, Ph.D.
New York, N.Y.

Bonnie Marcus
Shaker Heights, Ohio

Linda Mendelson
Chicago, Ill.

John C. Morris, M.D.
St. Louis, Mo.

David Moscow
Chicago, Ill.

John Osher
Jupiter, Fla.

David Hyde Pierce
Los Angeles, Calif.

Oscar Ponder
Dallas, Texas

James Prugh
Lakeview, Colo.

Roger A. Quick
Chicago, Ill.

Peter Rabins, M.D., M.P.H.
Baltimore, Md.

Dennis Revell
Sacramento, Calif.

John Sabl
Chicago, Ill.

Bettyly K. Saltzman
Chicago, Ill.

Gerald Sampson
Gainesville, Va.

Ronald Schilling, Ph.D.
Los Altos Hills, Calif.

Darlene Shiley
Pauma Valley, Calif.

Suzanne Swift
Larkspur, Calif.

Tenny Tsai
Mountain View, Calif.

Joanne Vidinsky
San Francisco, Calif.

**Directors Emeriti**
Leonard Berg, M.D.
St. Louis, Mo.

Peter T. Buchanan
Hobe Sound, Fla.

Ruth Buchanan Wheeler
Washington, D.C.

Nancy Emerson-Lombardo, Ph.D.
Acton, Mass.

Hilda Pridgeon
Bloomington, Minn.

Lonnie Wollin, Esq.
Englewood Cliffs, N.J.

Diane Young
River Ridge, La.

**Honorary Directors**
Princess Yasmin Aga Khan
New York, N.Y.

Mrs. Samuel A. Blank
Palm Beach, Fla.

Neil G. Bluhm
Chicago, Ill.

Edward C. Johnson 3d
Boston, Mass.

Nancy Reagan
Simi Valley, Calif.

Burton Resnick
New York, N.Y.

**Council of Former Chairs**
Jerome H. Stone
Chicago, Ill.

Stuart C. Roth
La Quinta, Calif.

Griff Healy
Newberg, Ore.

Orien Reid
Laverock, Pa.

Richard Kipper
Woody Creek, Colo.

**National Advisory Council**
Dominic Chianese
New York, N.Y.

Jack Ford
Spring Lake, N.J.

Soleil Moon Frye
Los Angeles, Calif.

Peter Gallagher
Santa Monica, Calif.

Victor Garber
Los Angeles, Calif.

Phyllis George
New York, N.Y.

Leeza Gibbons
Santa Monica, Calif.

Tracey Lawrence
Nashville, Tenn.

Mike Martz
Detroit, Mich.

Kate Mulgrew
New York, N.Y.

Jeanne Phillips
Beverly Hills, Calif.

Tim Ryan
Ketchum, Idaho
Medical and Scientific Advisory Council

Our Medical and Scientific Advisory Council comprises leading scientists and clinicians in the field of dementia research and treatment. They advise on our research funding, programs and policy.

**Chair**
Samuel E. Gandy, M.D., Ph.D.
Thomas Jefferson University
Farber Institute for Neurosciences

**Vice Chairs**
Ronald C. Petersen, M.D., Ph.D.
Mayo Clinic
Dept. of Neurology
Rochester, Minn.

Joseph D. Buxbaum, Ph.D.
Mount Sinai School of Medicine
Dept. of Psychiatry
New York, N.Y.

Peggye Dilworth-Anderson, Ph.D.
University of North Carolina
School of Public Health
Center for Aging and Diversity
University of North Carolina
Institute on Aging
Chapel Hill, N.C.

Steven H. Ferris, Ph.D.
New York University
School of Medicine
Alzheimer’s Disease Center
Silberstein Institute for Aging and Dementia
New York, N.Y.

Claudia H. Kawas, M.D.
University of California, Irvine
Dept. of Neurology and Neurobiology
and Behavior
Irvine, Calif.

William E. Klunk, M.D., Ph.D.
University of Pittsburgh
Western Psychiatric Institute and Clinic
Pittsburgh, Pa.

John C. Morris, M.D.
Washington University
School of Medicine
St. Louis, Mo.

Ralph A. Nixon, M.D., Ph.D.
Nathan Kline Institute
New York University School of Medicine
Center for Dementia Research
Orangeburg, N.Y.

James W. Simpkins, Ph.D.
University of North Texas
Health Science Center at Fort Worth
Dept. of Pharmacology and Neuroscience
Fort Worth, Texas

Yaakov Stern, Ph.D.
Cognitive Neuroscience Division
Taub Institute
New York, N.Y.

Linda Teri, Ph.D.
Northwest Research Group on Aging
University of Washington
School of Nursing
Dept. of Psychosocial and Community Health
Seattle, Wash.

Linda J. Van Eldik, Ph.D.
Northwestern University
Medical School
Dept. of Cell and Molecular Biology
Chicago, Ill.

**Senior Science Adviser**
Zaven S. Khachaturian, Ph.D.
Potomac, Md.

**Alzheimer’s Association Staff**

**National Office – Chicago, Ill.**

William H. Thies, Ph.D.
Vice President
Medical and Scientific Relations

Maria Carrillo, Ph.D.
Director
Medical and Scientific Relations

Corporations, Foundations and Membership Organizations

The generosity of these partners helps us to fund vital Alzheimer research, as well as both local and national educational programming. We are deeply grateful for their continuing support our mission.

Agilent Technologies, Inc.
American Apparel & Footwear Association
AWARE-Colorado
Bankers Life and Casualty Company
Baxter Healthcare Corporation
Blanchette Hooker Rockefeller Fund
Creative Memories
Dart Foundation
Diamond Tours, Inc.
Eisai Europe, Ltd
Eisenberg Family Trust
Elan Pharmaceuticals Corporation
Eli Lilly and Company
ExtendiCare Foundation, Inc.
F.M. Kirby Foundation, Inc.
Forest Laboratories, Inc.
GE Healthcare
Genworth Financial
GlaxoSmithKline
Golden Ventures Inc.
Harrah’s Entertainment
Intel Corp.
Janssen
Kimberly-Clark
Kindred Healthcare Inc.
Merck & Co., Inc.
MetLife Foundation
MetLife Insurance
National Active and Retired Federal Employees Association
Novartis Pharma AG
Order Sons of Italy in America
Ortho-McNeil Neurologics, Inc.
Pfizer Inc
Pragmaton Sigma Kappa Foundation
Rolex Watch U.S.A., Inc.
Tau Kappa Epsilon
United Airlines
Veranda Magazine
Voyager Pharmaceutical Corporation
Wal-Mart Foundation
Wyeth Pharmaceuticals

Executive Staff

**President and CEO**
Harry Johns

**Vice Presidents**

**Constituent Relations**
Angela Geiger

**Relationship Development**
Mark Germano

**Financial Officer**
Richard Hovland

**Advocacy**
Stephen McConnell, Ph.D.

**Chapter Relations**
Barbara Newhouse

**Medical and Scientific Relations**
William H. Thies, Ph.D.
Alzheimer’s Association Organization

The Alzheimer’s Association has built the most extensive nationwide organization of 24/7 Alzheimer information, referral and support services provided by professional staff and dedicated volunteers.

Arizona
Desert Southwest Chapter
Phoenix, Ariz.
602.528.0545

California
California Central Coast Chapter
Santa Barbara, Calif.
805.892.4259

California Southland Chapter
Los Angeles, Calif.
323.938.3379

Northern California and Northern Nevada Chapter
Mountain View, Calif.
650.962.8111

Orange County Chapter
Irvine, Calif.
949.955.9000

San Diego/Imperial Chapter
San Diego, Calif.
858.492.4400

Florida
Central and North Florida Chapter
Orlando, Fla.
407.228.4299

Florida Gulf Coast Chapter
Pinellas Park, Fla.
727.578.2558

Southeast Florida Chapter
West Palm Beach, Fla.
800.861.7826

Georgia
Georgia Chapter
Atlanta, Ga.
404.728.1181

Hawaii
Aloha Chapter
Honolulu, Hawaii
808.591.2771

Idaho
Greater Idaho Office
Boise, Idaho
208.384.1788

Illinois
Central Illinois Chapter
Peoria, Ill.
309.681.1100

Greater Illinois Chapter
Skokie, Ill.
847.933.2413

Indiana
Greater Indiana Chapter
Indianapolis, Ind.
317.575.9620

Iowa
Big Sioux Chapter
Sioux City, Iowa
712.279.5802

East Central Iowa Chapter
Cedar Rapids, Iowa
319.294.9699

Greater Iowa Chapter
West Des Moines, Iowa
515.440.2722

Kansas
Heart of America Chapter
Prairie Village, Kan.
913.831.3888

Central and Western Kansas Office
Wichita, Kan.
316.267.7333

Kentucky
Greater Kentucky and Southern Indiana Chapter
Louisville, Ky.
502.451.4266

Louisiana
Greater Louisiana Chapter
New Orleans, La.
504.568.7781

Maine
Greater Maine Chapter
Portland, Maine
207.772.0115

Maryland
Greater Maryland Chapter
Timonium, Md.
410.561.9099

Massachusetts
Greater Massachusetts Chapter
Watertown, Mass.
617.868.6718

Michigan
Greater Michigan Chapter
Ann Arbor, Mich.
734.677.3081

Minnesota
Greater Minnesota Chapter
Minneapolis, Minn.
952.830.0512

www.alz.org  1.800.272.3900
<table>
<thead>
<tr>
<th>State</th>
<th>Chapter Name</th>
<th>City</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>Mississippi Chapter</td>
<td>Jackson, Miss.</td>
<td>601.987.0020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>Mid-Missouri Chapter</td>
<td>Columbia, Mo.</td>
<td>573.443.8665</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southwest Missouri Chapter</td>
<td>Springfield, Mo.</td>
<td>417.886.2199</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>St. Louis Chapter</td>
<td>St. Louis, Mo.</td>
<td>314.432.3422</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>Montana Chapter</td>
<td>Billings, Mont.</td>
<td>406.252.3053</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>Great Plains Chapter</td>
<td>Lincoln, Neb.</td>
<td>402.420.2540</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midlands Chapter</td>
<td>Omaha, Neb.</td>
<td>402.502.4300</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Vermont/New Hampshire Chapter</td>
<td>Concord, N.H.</td>
<td>603.226.5868</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Greater New Jersey Chapter</td>
<td>Denville, N.J.</td>
<td>973.586.4300</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>New Mexico Chapter</td>
<td>Albuquerque, N.M.</td>
<td>505.266.4473</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>Central New York Chapter</td>
<td>Syracuse, N.Y.</td>
<td>315.472.4201</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hudson Valley/Rockland/Westchester, N.Y. Chapter</td>
<td>Poughkeepsie, N.Y.</td>
<td>845.471.2655</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Island</td>
<td>Long Island Chapter</td>
<td>Ronkonkoma, N.Y.</td>
<td>631.580.5100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>New York City Chapter</td>
<td>New York, N.Y.</td>
<td>646.744.2900</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northeastern New York Chapter</td>
<td>Albany, N.Y.</td>
<td>518.438.2217</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rochester Chapter</td>
<td>Rochester, N.Y.</td>
<td>585.760.5400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Western New York Chapter</td>
<td>Williamsville, N.Y.</td>
<td>716.626.0600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>Eastern North Carolina Chapter</td>
<td>Raleigh, N.C.</td>
<td>919.832.3732</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Western Carolina Chapter</td>
<td>Charlotte, N.C.</td>
<td>704.532.7392</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>Central Ohio Chapter</td>
<td>Columbus, Ohio</td>
<td>614.457.6003</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cleveland Area Chapter</td>
<td>Cleveland, Ohio</td>
<td>216.721.8457</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater Cincinnati Chapter</td>
<td>Cincinnati, Ohio</td>
<td>513.721.4284</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater East Ohio Area Chapter</td>
<td>Akron, Ohio</td>
<td>330.864.5646</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miami Valley Chapter</td>
<td>Dayton, Ohio</td>
<td>937.291.3332</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>Oklahoma Chapter</td>
<td>Tulsa, Okla.</td>
<td>918.481.7741</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>Oregon Chapter</td>
<td>Portland, Ore.</td>
<td>503.413.7115</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Delaware Valley Chapter</td>
<td>Philadelphia, Pa.</td>
<td>215.561.2919</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater Pennsylvania Chapter</td>
<td>Harrisburg, Pa.</td>
<td>717.651.5020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Rhode Island Chapter</td>
<td>Providence, R.I.</td>
<td>401.421.0008</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>South Carolina Chapter</td>
<td>Anderson, S.C.</td>
<td>864.224.3045</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>South Dakota Office</td>
<td>Sioux Falls, S.D.</td>
<td>605.339.4543</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>Eastern Tennessee Chapter</td>
<td>Knoxville, Tenn.</td>
<td>865.544.6288</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mid South Chapter</td>
<td>Nashville, Tenn.</td>
<td>615.292.4938</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northeast/Southeast Tennessee Chapter</td>
<td>Chattanooga, Tenn.</td>
<td>423.265.3600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>Capital of Texas Chapter</td>
<td>Austin, Texas</td>
<td>512.241.0420</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greater Dallas Chapter</td>
<td>Dallas, Texas</td>
<td>214.827.0062</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Houston and Southeast Texas Chapter</td>
<td>Houston, Texas</td>
<td>713.266.6400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Greater Wisconsin Chapter</td>
<td>Green Bay, Wis.</td>
<td>920.469.2110</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>South Central Wisconsin Chapter</td>
<td>Madison, Wis.</td>
<td>608.232.3400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southeastern Wisconsin Chapter</td>
<td>Milwaukee, Wis.</td>
<td>414.479.8800</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>Inland Northwest Chapter</td>
<td>Spokane, Wash.</td>
<td>509.473.3390</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Western and Central Washington State Chapter</td>
<td>Seattle, Wash.</td>
<td>206.363.5500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>West Virginia Chapter</td>
<td>Charleston, W.Va.</td>
<td>304.343.2717</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Greater Wisconsin Chapter</td>
<td>Green Bay, Wis.</td>
<td>920.469.2110</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>South Central Wisconsin Chapter</td>
<td>Madison, Wis.</td>
<td>608.232.3400</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southeastern Wisconsin Chapter</td>
<td>Milwaukee, Wis.</td>
<td>414.479.8800</td>
</tr>
</tbody>
</table>
Together, we have advanced research and care discoveries that would not have been possible without our donors.

Your compassion and generosity sustain us as we continue our quest for care and cure.

For more information, to make a donation or to become involved with your local Alzheimer’s Association chapter, please contact us at:

1.800.272.3900
info@alz.org
www.alz.org

Alzheimer’s Association
225 N. Michigan Ave., Fl. 17
Chicago, IL 60601-7633

1319 F Street N.W., Suite 500
Washington, D.C. 20004-1106
PET scan
pleiotropic
neurotransmitter
tau
leader
catalyst
innovator
research
care
support
www.alz.org
1.800.272.3900
Glossary of Alzheimer terms

**acetylcholine** – one of the dozens of specialized chemicals that carry information between nerve cells. Acetylcholine plays a key role in learning and memory.

**cholinergic system** – the brain’s nerve cell network that communicates chiefly with acetylcholine, and one of the circuits most severely damaged by Alzheimer’s disease.

**cholinergic hypothesis** – the theory that reduced levels of acetylcholine cause Alzheimer’s disease by crippling and destroying cholinergic system cells that depend on it.

**cholinesterase inhibitors** – first-generation Alzheimer drugs based on the cholinergic hypothesis. They increase available acetylcholine by blocking the process that recycles it. Experience with these drugs suggests that decreased acetylcholine levels are likely an effect rather than a cause of Alzheimer’s disease.

**amyloid hypothesis** – the theory that flaws in processes governing the brain’s production or removal of beta-amyloid are the chief cause of Alzheimer’s disease. It is the current leading Alzheimer theory.

**beta-amyloid** – a fragment produced from a larger protein in a series of chemical steps. It is the chief substance in plaques, one of the hallmark microscopic abnormalities in the Alzheimer brain.

**amyloid precursor protein (APP)** – the parent molecule of beta-amyloid. Found in cells throughout the body, its normal function is not yet known.

**Pittsburgh compound B (PIB)** – a tracer molecule. When injected into the bloodstream, PIB passes into the brain, where it attaches to beta-amyloid and “lights up” in a positron emission tomography (PET) scan.

**positron emission tomography (PET) scan** – a brain imaging technology. A PET scan usually indicates levels of activity in various brain regions by showing the amount of sugar being used by brain cells. When performed with the specialized tracer molecule Pittsburgh compound B (PIB), a PET scan shows levels of beta-amyloid present in the brain.

**tau** – a protein that stabilizes a vital transport system carrying food and other essential substances throughout nerve cells. In Alzheimer’s disease, tau undergoes chemical changes and twists into tangles, another hallmark brain abnormality.

**vascular brain disease** – any condition impairing the health of the brain’s blood vessels and their ability to carry vital oxygen and nutrients to brain cells. Examples include fatty deposits partially blocking arteries, major strokes and multiple tiny strokes.
What is Alzheimer’s disease?

Alzheimer’s is a progressive, fatal disease that kills brain cells and destroys mental and physical functions. It is not normal aging, and currently, there is no known cause or cure.

Today, more than 5 million Americans have Alzheimer’s. By 2050, that number could reach 16 million.

The impact of the disease extends far beyond those numbers to millions more family members, friends, co-workers and caregivers. Each year the disease costs American businesses $61 billion in lost productivity and health care expenses.

If we don’t find effective methods of treatment, Alzheimer’s will bankrupt families, communities and health care systems. In the next five years alone, Alzheimer’s-related costs will cause annual Medicare and Medicaid expenses to soar 65 percent.

Scientists are learning more every day about the characteristics of Alzheimer’s and promising treatments to slow or stop its progress. There is hope.

Contact the Alzheimer’s Association:
1.800.272.3900
www.alz.org