

		FOR BHF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

I. IDPH Facility ID Number: 0041590

Facility Name: International Village

Address: 4815 South Western Avenue Chicago 60609
 Number City Zip Code

County: Cook

Telephone Number: (773) 927-4200 **Fax #** (773) 927-8742

HFS ID Number: 363928303001

Date of Initial License for Current Owners: 09/11/00

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>218</u>	Skilled (SNF)	<u>218</u>	<u>79,570</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>218</u>	TOTALS	<u>218</u>	<u>79,570</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>50,371</u>	<u>1,352</u>	<u>7,893</u>	<u>59,616</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>50,371</u>	<u>1,352</u>	<u>7,893</u>	<u>59,616</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.92%

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

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

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

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

None

F. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 9/11/00

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

YES Date 9/11/00 NO

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

YES NO If YES, enter number of beds certified 218 and days of care provided 7,270

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	278,089	98,055	20,696	396,840		396,840	1,191	398,031		1
2	Food Purchase		258,296		258,296		258,296	10,000	268,296		2
3	Housekeeping	243,831	49,022	1,514	294,367		294,367	(4,247)	290,120		3
4	Laundry	46,614	16,289	76	62,979		62,979	(4)	62,975		4
5	Heat and Other Utilities			297,254	297,254		297,254	2,357	299,611		5
6	Maintenance	99,961	(34)	196,816	296,743		296,743	7,033	303,776		6
7	Other (specify):*							4,009	4,009		7
8	TOTAL General Services	668,495	421,628	516,356	1,606,479		1,606,479	20,339	1,626,818		8
	B. Health Care and Programs										
9	Medical Director			50,500	50,500		50,500		50,500		9
10	Nursing and Medical Records	3,088,004	176,749	375,003	3,639,756		3,639,756	(13,934)	3,625,822		10
10a	Therapy	141,804		55,290	197,094		197,094	563	197,657		10a
11	Activities	147,649	11,856	2,242	161,747		161,747		161,747		11
12	Social Services	160,034		3,713	163,747		163,747		163,747		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,539	5,539		15
16	TOTAL Health Care and Programs	3,537,491	188,605	486,748	4,212,844		4,212,844	(7,832)	4,205,012		16
	C. General Administration										
17	Administrative	117,534		1,000	118,534		118,534	36,203	154,737		17
18	Directors Fees										18
19	Professional Services			400,275	400,275		400,275	(280,001)	120,274		19
20	Dues, Fees, Subscriptions & Promotions			93,707	93,707		93,707	(35,120)	58,587		20
21	Clerical & General Office Expenses	108,089	26,178	382,531	516,798		516,798	(112,794)	404,004		21
22	Employee Benefits & Payroll Taxes			764,414	764,414		764,414	(10,299)	754,115		22
23	Inservice Training & Education			366	366		366		366		23
24	Travel and Seminar			1,204	1,204		1,204	5,842	7,046		24
25	Other Admin. Staff Transportation			170	170		170		170		25
26	Insurance-Prop.Liab.Malpractice			233,733	233,733		233,733	2,583	236,316		26
27	Other (specify):*							32,924	32,924		27
28	TOTAL General Administration	225,623	26,178	1,877,400	2,129,201		2,129,201	(360,661)	1,768,540		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,431,609	636,411	2,880,504	7,948,524		7,948,524	(348,154)	7,600,370		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village #0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			98,926	98,926		98,926	445,230	544,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			438,657	438,657		438,657	450,118	888,775			32
33	Real Estate Taxes			309,289	309,289		309,289	1,938	311,227			33
34	Rent-Facility & Grounds			1,200,647	1,200,647		1,200,647	(1,191,470)	9,177			34
35	Rent-Equipment & Vehicles			8,783	8,783		8,783	1,737	10,520			35
36	Other (specify):*			3,978	3,978		3,978	11,794	15,772			36
37	TOTAL Ownership			2,060,280	2,060,280		2,060,280	(280,653)	1,779,627			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	261,875	541,813	408,508	1,212,196		1,212,196	(90,003)	1,122,193			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,355	119,355		119,355		119,355			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	261,875	541,813	527,863	1,331,551		1,331,551	(90,003)	1,241,548			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,693,484	1,178,224	5,468,647	11,340,355		11,340,355	(718,810)	10,621,545			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(782)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(54,746)	30		9
10	Interest and Other Investment Income	(125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58)	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	(56,511)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(243,396)	21		24
25	Fund Raising, Advertising and Promotional	(38,048)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(65)	20		28
29	Other-Attach Schedule	(274,444)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (668,675)		\$	30

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

		1	2	
		Amount	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)	(50,135)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,135)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (718,810)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

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				(11)	374		(371)	1,199				1,191	1
2	Food Purchase	(58)			(20)				10,078				10,000	2
3	Housekeeping				(4,247)								(4,247)	3
4	Laundry				(4)								(4)	4
5	Heat and Other Utilities					2,357							2,357	5
6	Maintenance	(4,001)			(80)	5,760		5,195	159				7,033	6
7	Other (specify):*						246	1,360	2,403				4,009	7
8	TOTAL General Services	(4,059)			(4,362)	8,491	246	6,184	13,839				20,339	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(607)			(13,327)								(13,934)	10
10a	Therapy							563					563	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						5,462	77					5,539	15
16	TOTAL Health Care and Programs	(607)			(13,327)		5,462	640					(7,832)	16
	C. General Administration													
17	Administrative					3,862		31,179	1,162				36,203	17
18	Directors Fees													18
19	Professional Services	(210)				(279,817)			26				(280,001)	19
20	Fees, Subscriptions & Promotions	(40,214)			(5)	5,065			34				(35,120)	20
21	Clerical & General Office Expenses	(305,118)	345			18,827		170,483	2,669				(112,794)	21
22	Employee Benefits & Payroll Taxes				(362)		(9,937)						(10,299)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,918			924				5,842	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					1,757			826				2,583	26
27	Other (specify):*						3,991	28,933					32,924	27
28	TOTAL General Administration	(345,542)	345		(366)	(245,388)	(5,946)	230,595	5,641				(360,661)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(350,208)	345		(18,055)	(236,897)	(238)	237,419	19,480				(348,154)	29

STATE OF ILLINOIS

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(54,746)	458,747			24,550			443	16,236			445,230	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(263,721)	702,511			4,098			1,486	5,744			450,118	32
33	Real Estate Taxes					1,938							1,938	33
34	Rent-Facility & Grounds		(1,200,647)			9,177							(1,191,470)	34
35	Rent-Equipment & Vehicles					1,654			83				1,737	35
36	Other (specify):*		11,794										11,794	36
37	TOTAL Ownership	(318,467)	(27,595)			41,417			2,012	21,980			(280,653)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(6,939)				(34,279)	(48,785)			(90,003)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(6,939)				(34,279)	(48,785)			(90,003)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(668,675)	(27,250)		(24,994)	(195,480)	(238)	237,419	(12,787)	(26,805)			(718,810)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Highlander Care Center LLC		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,200,647	Highlander Care Center LLC		\$	\$ (1,200,647)	1
2	V	21 Trust & Filing Fees		Highlander Care Center LLC		345	345	2
3	V	30 Depreciation		Highlander Care Center LLC		458,747	458,747	3
4	V	36 Amortization		Highlander Care Center LLC		11,794	11,794	4
5	V	32 Interest		Highlander Care Center LLC		702,511	702,511	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,200,647			\$ 1,173,397	\$ * (27,250)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 74,006	\$ 74,006	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	74,006	CCS EMPLOYEE BENEFIT GROUP	100.00%		(74,006)	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			\$ 74,006			\$ 74,006	\$ *	39

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$ 109	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 98	\$ (11)	15
16	V	02 FOOD	203	XCEL MEDICAL SUPPLY, LLC	100.00%	183	(20)	16
17	V	03 HOUSEKEEPING	42,834	XCEL MEDICAL SUPPLY, LLC	100.00%	38,587	(4,247)	17
18	V	04 LAUNDRY	39	XCEL MEDICAL SUPPLY, LLC	100.00%	35	(4)	18
19	V	06 REPAIRS & MAINTENANCE	810	XCEL MEDICAL SUPPLY, LLC	100.00%	730	(80)	19
20	V	10 NURSING	134,424	XCEL MEDICAL SUPPLY, LLC	100.00%	121,097	(13,327)	20
21	V	11 ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM	48	XCEL MEDICAL SUPPLY, LLC	100.00%	43	(5)	22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS	3,648	XCEL MEDICAL SUPPLY, LLC	100.00%	3,286	(362)	24
25	V	39 ANCILLARY	69,989	XCEL MEDICAL SUPPLY, LLC	100.00%	63,050	(6,939)	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		\$ 252,104			\$ 227,110	\$ * (24,994)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 374	\$ 374	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	2,357	2,357	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	5,760	5,760	17
18	V			Care Centers, Inc.	100.00%			18
19	V	17 Administration		Care Centers, Inc.	100.00%	3,862	3,862	19
20	V	19 Professional Fees	301,443	Care Centers, Inc.	100.00%	21,626	(279,817)	20
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	5,065	5,065	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	18,827	18,827	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	4,918	4,918	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	1,757	1,757	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	24,550	24,550	25
26	V	32 Interest		Care Centers, Inc.	100.00%	4,098	4,098	26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,938	1,938	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	9,177	9,177	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,654	1,654	29
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02 Food		Care Centers, Inc.	100.00%			31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 301,443			\$ 105,963	\$ * (195,480)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 1,742	Care Centers, Inc.	100.00%	\$ 1,742		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	246	246	16
17	V	10 Nursing Salary	32,516	Care Centers, Inc.	100.00%	32,516		17
18	V	10a Rehab Salary	6,806	Care Centers, Inc.	100.00%	6,806		18
19	V							19
20	V							20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,462	5,462	21
22	V	17 Administration Salary	1,000	Care Centers, Inc.	100.00%	1,000		22
23	V	21 Office Salary	25,147	Care Centers, Inc.	100.00%	25,147		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,991	3,991	24
25	V	22 Employee Benefits	9,937	Care Centers, Inc.	100.00%		(9,937)	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		\$ 77,148			\$ 76,910	\$ * (238)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ 4,642	Care Centers, Inc.	100.00%	\$ 4,271	\$ (371)	15
16	V							16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	5,195	5,195	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,360	1,360	18
19	V							19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	563	563	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	77	77	21
22	V							22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	31,179	31,179	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	170,483	170,483	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	28,933	28,933	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		\$ 4,642			\$ 242,061	\$ * 237,419	39

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 19,156	Care Centers, Inc. - Health Systems Division	100.00%	\$ 4,533	\$ (14,623)	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	10,078	10,078	16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	159	159	17
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	1,162	1,162	18
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	26	26	19
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	34	34	20
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	2,669	2,669	21
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	924	924	22
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	826	826	23
24	V	30 Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	443	443	24
25	V	32 Interest		Care Centers, Inc. - Health Systems Division	100.00%	1,486	1,486	25
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	83	83	26
27	V	39 Ancillary Enteral Supplies	72,331	Care Centers, Inc. - Health Systems Division	100.00%	38,052	(34,279)	27
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	15,822	15,822	28
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	2,403	2,403	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		\$ 91,487			\$ 78,700	\$ * (12,787)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 16,236	\$ 16,236	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	5,744	5,744	16
17	V	39 Vent Reimbursement	48,785	Vent Lease, LLC.	100.00%		(48,785)	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		\$ 48,785			\$ 21,980	\$ * (26,805)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Owner	Clerical	2.29%	see attached	0.49	1.23%	Alloc Salary	\$ 603	22-7	1
2	Kim Rudolph	Owner	Clerical	2.29%	see attached	0.57	1.63%	Alloc Salary	979	22-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	see attached	2.19	3.98%	Alloc Salary	2,929	17-7	3
4	Eric Rothner	Relative	Administrative	0.00%	see attached	1.25	2.73%	Alloc Salary	3,042	17-7	4
5	Gale Rothner	Relative	Administrative	0.00%	see attached	1.39	3.97%	Alloc Salary	3,106	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,659		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 74,006	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				\$	\$		\$ 74,006	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 W. MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$ 98	1
2	02	FOOD	Direct Allocation					183	2
3	03	HOUSEKEEPING	Direct Allocation					38,587	3
4	04	LAUNDRY	Direct Allocation					35	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					730	5
6	10	NURSING	Direct Allocation					121,097	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation					43	8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation					3,286	10
11	39	ANCILLARY	Direct Allocation					63,050	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				\$	\$		\$ 227,110	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	\$ 9,406	\$ 59,616	\$ 374	1
2	05	Utilities	Patient Days	1,497,287	32	59,188	59,616	2,357	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661	59,616	5,760	3
4									4
5	17	Administration	Patient Days	1,497,287	32	97,000	59,616	3,862	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148	59,616	21,626	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217	59,616	5,065	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845	59,616	18,827	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511	59,616	4,918	9
10	26	Insurance	Patient Days	1,497,287	32	44,126	59,616	1,757	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575	59,616	24,550	11
12	32	Interest	Patient Days	1,497,287	32	102,930	59,616	4,098	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662	59,616	1,938	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488	59,616	9,177	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530	59,616	1,654	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,661,288	\$	\$ 105,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost		301,710	301,710		1,742	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		46,639			246	2
3	10	Nursing Salary	Direct Cost		425,833	425,833		32,516	3
4	10a	Rehab Salary	Direct Cost		55,464	55,464		6,806	4
5									5
6									6
7	15	Emp. Ben. - Healthcare	Direct Cost		67,757			5,462	7
8	17	Administration Salary	Direct Cost		5,566	5,566		1,000	8
9	21	Office Salary	Direct Cost		419,879	419,879		25,147	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		71,906			3,991	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				\$ 1,394,755	\$ 1,208,453		\$ 76,910	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	59,616	4,271	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	59,616	5,195	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		59,616	1,360	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	59,616	563	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		59,616	77	7
8										8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	59,616	31,179	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	59,616	170,483	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		59,616	28,933	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					\$ 6,079,517	\$ 5,316,753		\$ 242,061	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452	46,000		91,486	4,533	1
2	02	Food	Income		160,931			10,078	2
3	06	Maintenance	Billable Income	928,452	1,614		91,486	159	3
4	17	Administration	Billable Income	928,452	11,797		91,486	1,162	4
5	19	Professional Fees	Billable Income	928,452	262		91,486	26	5
6	20	Dues & Subscriptions	Billable Income	928,452	342		91,486	34	6
7	21	Office & Clerical	Billable Income	928,452	27,087		91,486	2,669	7
8	24	Travel & Seminar	Billable Income	928,452	9,381		91,486	924	8
9	26	Insurance	Billable Income	928,452	8,379		91,486	826	9
10	30	Depreciaton	Billable Income	928,452	4,499		91,486	443	10
11	32	Interest	Billable Income	928,452	15,077		91,486	1,486	11
12	35	Rent - Equipment & Auto	Billable Income	928,452	843		91,486	83	12
13	39	Ancillary Enteral Supplies	Income		327,517			38,052	13
14	01	Dietary - Salary	Billable Income	928,452	160,568	160,568	91,486	15,822	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452	24,382		91,486	2,403	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 798,679	\$ 160,568		\$ 78,700	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	\$ 197,493	\$ 48,785	\$ 16,236	1
2	32	Interest	Direct Billing	593,410	29	69,863	48,785	5,744	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					\$ 267,356	\$	\$ 21,980	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Corus Bank		X	Mortgage			\$	\$ 1,999,984		\$ 473,415	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Diawa		X	Line of Credit				6,122,574		404,157	6									
7	Shareholder Loan	X		Working Capital				600,000		34,500	7									
8	See Supplemental Schedule							7,118,629		(23,172)	8									
9	TOTAL Facility Related						\$	\$ 15,841,187		\$ 888,900	9									
B. Non-Facility Related*																				
10	Interest Income									(125)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		(125)	14									
15	TOTALS (line 9+line14)						\$	\$ 15,841,187		\$ 888,775	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* 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 International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Less: Shareholder Interest	X					\$	\$			\$ (34,500)	8
9	Applewood (related party)	X						4,276,963			140,170	9
10	South Shore (related party)	X						2,841,666			88,926	10
11	Less: Related Party Interest	X									(229,096)	11
12	Allocated from Care Centers		X								5,584	12
13	Allocated from Vent Lease		X								5,744	13
14	TOTAL Working Capital							7,118,629			(23,172)	14
	B. Non-Facility Related*											
15							\$	\$			\$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.		\$	<u>310,609</u>	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.)		\$	<u>304,332</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(6,277)</u>	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>317,504</u>	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.)		\$		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 \$ _____ For _____ 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.		\$	<u>311,227</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	<u>5,865</u>	<u>8</u>	
	2001	<u>357,200</u>	<u>9</u>	
	2002	<u>304,867</u>	<u>10</u>	
	2003	<u>295,822</u>	<u>11</u>	
	2004	<u>302,394</u>	<u>12</u>	
<u>2005 Accrual = 2004 tax \$302,394 x 1.05 = \$317,504</u>				
<u>Allocated from Care Centers \$1938</u>				

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME International Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041590

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>20-07-104-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>219,315.06</u>	\$ <u>219,315.06</u>
2. <u>20-07-104-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>902.12</u>	\$ <u>902.12</u>
3. <u>20-07-104-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>776.90</u>	\$ <u>776.90</u>
4. <u>20-07-104-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>276.45</u>	\$ <u>276.45</u>
5. <u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>72,715.49</u>	\$ <u>72,715.49</u>
6. <u>20-07-104-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,506.36</u>	\$ <u>7,506.36</u>
7. <u>20-07-104-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>901.12</u>	\$ <u>901.12</u>
8. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>113,458.70</u>	\$ <u>1,938.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>415,852.20</u>	\$ <u>304,331.50</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME International Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041590

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number International Village

0041590 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,132 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>115,710</u>	<u>1995</u>	<u>\$ 901,533</u>	1
2	<u>Allocated from 2201 Main LLC</u>			<u>14,003</u>	2
3	TOTALS	115,710		\$ 915,536	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			2000	169,034		20	8,450	8,450	40,434	9
10	Various			2001	50,660		20	2,537	2,537	11,693	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	12,627,413	323,779		360,783	37,004	1,894,111	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	54,957	2,252		2,252		6,788	68
69	Financial Statement Depreciation		98,926			(98,926)		69
70	TOTAL (lines 4 thru 69)	\$ 12,902,064	\$ 424,957		\$ 374,022	\$ (50,935)	\$ 1,953,026	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,902,064	\$ 424,957		\$ 374,022	\$ (50,935)	\$ 1,953,026	1
2	Telephones	2002	804		20	80	80	322	2
3	Light Timmer & Control Board	2002	1,101		20	110	110	440	3
4	Phone Wiring	2002	518		20	52	52	207	4
5	Phone Wiring	2002	1,133		20	113	113	453	5
6	Boiler Work-Varius Invoices	2002	8,330		20	833	833	3,263	6
7	Telephone Work	2002	592		20	59	59	232	7
8	Telephone Work	2002	2,300		20	230	230	882	8
9	Check & Adjust System	2002	701		20	70	70	257	9
10	Telephones	2002	2,111		20	211	211	756	10
11	Roof Repairs	2002	1,246		20	125	125	446	11
12	Repair Elevator Door-3Rd Floor-Fire Damage	2002	3,201		20	640	640	2,241	12
13	Rehang Elevator Doors	2002	1,080		20	216	216	756	13
14	Repair Bathroom Showers	2002	1,858		20	186	186	635	14
15	Elevator Repair	2002	755		20	38	38	126	15
16	A/C Chiller Repair	2002	7,380		20	369	369	1,199	16
17	6' Chain Link Fence	2003	2,295		20	115	115	344	17
18	Carpet Cleaning	2003	1,072		20	107	107	313	18
19	Corner Guards	2003	1,031		20	52	52	150	19
20	Electrical Work	2003	5,250		20	525	525	1,488	20
21	Electrical Work	2003	5,540		20	554	554	1,570	21
22	6' Double Swing Gate	2003	1,098		20	110	110	311	22
23	Electrical Work	2003	2,390		20	239	239	657	23
24	Shower Equip & Repairs	2003	1,858		20	93	93	248	24
25	Wiring Repair	2003	556		20	56	56	139	25
26	Ceiling Mounts	2003	1,127		20	56	56	136	26
27	Humidity-Heat System	2003	500		20	50	50	117	27
28	Installment On Heat System	2003	500		20	50	50	113	28
29	Installment On Heat System	2003	500		20	50	50	108	29
30	Installment On Heat System	2003	548		20	55	55	119	30
31	Repair Broken Main Line	2004	1,550		20	155	155	181	31
32	Tile & Carpeting Work	2004	2,502		20	250	250	292	32
33	Tile For 2Nd Fl	2004	2,014		20	201	201	235	33
34	TOTAL (lines 1 thru 33)		\$ 12,965,505	\$ 424,957		\$ 380,072	\$ (44,885)	\$ 1,971,762	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,965,505	\$ 424,957		\$ 380,072	\$ (44,885)	\$ 1,971,762	1
2	Replace Tempering Valve	2004	657		20	66	66	71	2
3	Tel System Repair	2004	584		20	117	117	234	3
4	Electric Door Opener	2004	5,223		20	1,045	1,045	1,654	4
5	Roof Exhauster	2004	1,392		20	278	278	394	5
6	Door Keypad - Timer	2004	2,245		20	449	449	599	6
7	Frozen Pipes Repair	2004	682		20	68	68	136	7
8	Roof Work	2004	3,200		20	320	320	373	8
9	Relocating Water Pumps	2004	580		20	58	58	106	9
10	Repair Elevator	2004	1,559		20	156	156	273	10
11	New Sidewalk	2004	1,450		20	145	145	193	11
12	Reconstruct Elevator	2004	13,100		20	1,310	1,310	1,747	12
13	Door Alarms	2004	570		20	29	29	38	13
14	Showers - Posigrip	2004	825		20	41	41	55	14
15	Camera System	2005	16,128		20	2,419	2,419	2,419	15
16	Filters	2005	2,680		20	156	156	156	16
17	Valves	2005	4,023		20	201	201	201	17
18	Settlement On Issues	2005	5,493		20	183	183	183	18
19	Hvac Repair	2005	1,635		20	14	14	14	19
20	Hvac Repair	2005	1,584		20	40	40	40	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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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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16									16
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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)	\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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
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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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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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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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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
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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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	1	
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	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
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19									19
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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)		\$ 13,029,115	\$ 424,957		\$ 387,167	\$ (37,790)	\$ 1,980,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	218		2000	2000	\$ 12,627,413	\$ 323,779	35	\$ 360,783	\$ 37,004	\$ 1,894,111	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 12,627,413	\$ 323,779		\$ 360,783	\$ 37,004	\$ 1,894,111	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	2201 Main LLC		2002	2002	\$ 19,297	\$ 495		\$ 495	\$	\$ 1,629	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Allocation from 2201 Main LLC			2002	15,941	797	20	797		2,790	9
10	Allocation from 2201 Main LLC			2003	18,786	939	20	939		2,348	10
11	Allocation from 2201 Main LLC			2005	933	21	20	21		21	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 54,957	\$ 2,252		\$ 2,252	\$	\$ 6,788	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,287,847	\$ 171,586	\$ 149,079	\$ (22,507)	10	\$ 665,794	71
72	Current Year Purchases	57,210	390	5,941	5,551	10	5,941	72
73	Fully Depreciated Assets	19,726				10	19,726	73
74								74
75	TOTALS	\$ 1,364,783	\$ 171,976	\$ 155,020	\$ (16,956)		\$ 691,461	75

D. Vehicle Depreciation (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		Alloc from Care Centers		\$ 26,887	\$ 1,969	\$ 1,969	\$	5	\$ 20,360	76
77										77
78										78
79										79
80	TOTALS			\$ 26,887	\$ 1,969	\$ 1,969	\$		\$ 20,360	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)	\$ 15,336,321	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 598,902	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 544,156	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (54,746)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,692,469	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Care Centers				9,177			6
7	TOTAL				\$ 9,177			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 10,519 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	39 - 03	hrs	\$		\$ 158,364	\$		\$ 158,364	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			38,165			38,165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			158,449			158,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				257,486		257,486	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>			261,875		53,530	284,327		599,732	13
14	TOTAL			\$ 261,875		\$ 408,508	\$ 541,813		\$ 1,212,196	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(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	\$ 1,000	\$ 252,044	1
2	Cash-Patient Deposits	43,799	43,799	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,077,077	3,077,077	3
4	Supply Inventory (priced at)		9,065	4
5	Short-Term Investments			5
6	Prepaid Insurance	134,635	134,635	6
7	Other Prepaid Expenses	14,667	14,667	7
8	Accounts Receivable (owners or related parties)	697,650	1	8
9	Other(specify): <u>See Attached Schedule</u>	64,338	122,840	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,033,166	\$ 3,654,128	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,156,831	13
14	Buildings, at Historical Cost		9,618,909	14
15	Leasehold Improvements, at Historical Cost	289,634	1,527,837	15
16	Equipment, at Historical Cost	495,601	2,809,261	16
17	Accumulated Depreciation (book methods)	(441,796)	(4,597,931)	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): <u>See Attached Schedule</u>		198,775	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 343,439	\$ 10,713,682	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,376,605	\$ 14,367,810	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,062,609	\$ 1,062,610	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,195	43,195	28
29	Short-Term Notes Payable	6,122,574	6,122,574	29
30	Accrued Salaries Payable	125,824	125,824	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,992	9,992	31
32	Accrued Real Estate Taxes(Sch.IX-B)	317,504	317,504	32
33	Accrued Interest Payable	213,906	213,906	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	4,907	3,856,328	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,900,511	\$ 11,751,933	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000	600,000	39
40	Mortgage Payable		9,118,613	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 600,000	\$ 9,718,613	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,500,511	\$ 21,470,546	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,123,906)	\$ (7,102,736)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,376,605	\$ 14,367,810	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,225,187)	1
2	Restatements (describe):		2
3	<u>Nursing Supplies</u>	692	3
4	<u>Prior Period Income</u>	34,226	4
5	<u>Depreciation</u>	(12,479)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,202,748)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,921,158)	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)	\$ (1,921,158)	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)	\$ (4,123,906)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,273,504	1
2	Discounts and Allowances for all Levels	(1,791,859)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,481,645	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,480,676	6
7	Oxygen	29,835	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,510,511	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	224,511	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,791	19
20	Radiology and X-Ray	11,300	20
21	Other Medical Services	147,229	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 425,831	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,085	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,419,197	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,606,479	31
32	Health Care	4,212,844	32
33	General Administration	2,129,201	33
B. Capital Expense			
34	Ownership	2,060,280	34
C. Ancillary Expense			
35	Special Cost Centers	1,212,196	35
36	Provider Participation Fee	119,355	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,340,355	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,921,158)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,921,158)	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,231	2,494	\$ 94,850	\$ 38.03	1
2	Assistant Director of Nursing	2,038	2,779	83,270	29.96	2
3	Registered Nurses	18,945	20,841	561,874	26.96	3
4	Licensed Practical Nurses	44,501	48,393	1,124,002	23.23	4
5	CNAs & Orderlies	111,777	120,094	1,146,197	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	10,674	11,713	261,875	22.36	7
8	Rehab/Therapy Aides	9,356	10,171	141,804	13.94	8
9	Activity Director	1,973	2,729	31,859	11.67	9
10	Activity Assistants	13,341	14,429	115,790	8.02	10
11	Social Service Workers	11,429	12,498	160,034	12.80	11
12	Dietician	690	744	9,161	12.31	12
13	Food Service Supervisor	3,116	3,559	51,327	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,006	5,435	52,551	9.67	15
16	Dishwashers	20,807	22,343	165,050	7.39	16
17	Maintenance Workers	5,730	6,008	99,961	16.64	17
18	Housekeepers	29,465	31,569	243,831	7.72	18
19	Laundry	5,302	5,792	46,614	8.05	19
20	Administrator	1,613	1,635	59,052	36.12	20
21	Assistant Administrator	2,520	2,612	58,482	22.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,593	9,243	108,089	11.69	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	3,611	3,955	50,624	12.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,325	2,440	27,187	11.14	33
34	TOTAL (lines 1 - 33)	315,043	341,476	\$ 4,693,484 *	\$ 13.74	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	291	\$ 16,054	01-03	35
36	Medical Director	monthly	50,500	09-03	36
37	Medical Records Consultant	7	248	10-03	37
38	Nurse Consultant	153	7,665	10-03	38
39	Pharmacist Consultant	monthly	3,270	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	968	48,412	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,242	11-03	44
45	Social Service Consultant	69	3,713	12-03	45
46	Other(specify) <u>Therapy Consult</u>	1	72	10A-03	46
47	<u>Dental Consultant</u>	6	600	10-03	47
48	<u>CCI - see attached</u>		43,964	various	48
49	TOTAL (lines 35 - 48)	1,542	\$ 176,740		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,077	\$ 55,543	10-03	50
51	Licensed Practical Nurses	8,547	275,160	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,624	\$ 330,703		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. Illinois Council on Long Term Care \$8,225
- (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? _____
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,913 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 119,355
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. \$ 0 Has any meal income been offset against related costs? No 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT