

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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
<b>IRS Exemption Code</b> _____	<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 01/01/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; 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: 01/01/06 Ending: 12/31/06

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>48,103</u>	<u>2,457</u>	<u>8,599</u>	<u>59,159</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>48,103</u>	<u>2,457</u>	<u>8,599</u>	<u>59,159</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.35%

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 09/11/00

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

YES  Date 09/11/00 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 8,558

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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	
	<b>A. General Services</b>											
1	Dietary	303,505	101,979	21,580	427,064		427,064	6,321	433,385			1
2	Food Purchase		260,804		260,804		260,804	(1,855)	258,949			2
3	Housekeeping	244,597	39,386		283,983		283,983	(2,762)	281,221			3
4	Laundry	56,181	23,853		80,034		80,034		80,034			4
5	Heat and Other Utilities			287,012	287,012		287,012	2,588	289,600			5
6	Maintenance	100,261		190,356	290,617		290,617	11,346	301,963			6
7	Other (specify):*							1,566	1,566			7
8	<b>TOTAL General Services</b>	<b>704,544</b>	<b>426,022</b>	<b>498,948</b>	<b>1,629,514</b>		<b>1,629,514</b>	<b>17,203</b>	<b>1,646,717</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			66,250	66,250		66,250		66,250			9
10	Nursing and Medical Records	3,043,884	181,259	150,163	3,375,306		3,375,306	5,435	3,380,741			10
10a	Therapy	172,758		78,745	251,503		251,503	2,717	254,220			10a
11	Activities	148,810	11,239	2,649	162,698		162,698	(6)	162,692			11
12	Social Services	164,634	4	2,093	166,731		166,731	13,300	180,031			12
13	CNA Training											13
14	Program Transportation			55	55		55		55			14
15	Other (specify):*							5,314	5,314			15
16	<b>TOTAL Health Care and Programs</b>	<b>3,530,086</b>	<b>192,502</b>	<b>299,955</b>	<b>4,022,543</b>		<b>4,022,543</b>	<b>26,760</b>	<b>4,049,303</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	121,040			121,040		121,040	47,607	168,647			17
18	Directors Fees											18
19	Professional Services			570,345	570,345	(3,500)	566,845	(408,569)	158,276			19
20	Dues, Fees, Subscriptions & Promotions			70,296	70,296		70,296	(11,215)	59,081			20
21	Clerical & General Office Expenses	113,347	21,593	664,374	799,314		799,314	(459,011)	340,303			21
22	Employee Benefits & Payroll Taxes			745,315	745,315		745,315	(2,028)	743,287			22
23	Inservice Training & Education			819	819		819		819			23
24	Travel and Seminar			601	601		601	3,917	4,518			24
25	Other Admin. Staff Transportation			1,007	1,007		1,007	210	1,217			25
26	Insurance-Prop.Liab.Malpractice			232,647	232,647		232,647	(214)	232,433			26
27	Other (specify):*							29,258	29,258			27
28	<b>TOTAL General Administration</b>	<b>234,387</b>	<b>21,593</b>	<b>2,285,404</b>	<b>2,541,384</b>	<b>(3,500)</b>	<b>2,537,884</b>	<b>(800,045)</b>	<b>1,737,839</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,469,017</b>	<b>640,117</b>	<b>3,084,307</b>	<b>8,193,441</b>	<b>(3,500)</b>	<b>8,189,941</b>	<b>(756,082)</b>	<b>7,433,859</b>			<b>29</b>

\*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: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			77,075	77,075		77,075	628,313	705,388		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			672,833	672,833		672,833	165,483	838,316		32
33	Real Estate Taxes			308,707	308,707	3,500	312,207	2,158	314,365		33
34	Rent-Facility & Grounds			816,000	816,000		816,000	(811,830)	4,170		34
35	Rent-Equipment & Vehicles			7,503	7,503		7,503	1,245	8,748		35
36	Other (specify):*							23,271	23,271		36
37	<b>TOTAL Ownership</b>			1,882,118	1,882,118	3,500	1,885,618	8,640	1,894,258		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	183,961	613,870	529,128	1,326,959		1,326,959	(88,693)	1,238,266		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	<b>TOTAL Special Cost Centers</b>	183,961	613,870	648,483	1,446,314		1,446,314	(88,693)	1,357,621		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,652,978	1,253,987	5,614,908	11,521,873		11,521,873	(836,135)	10,685,738		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: 01/01/06

Ending: 12/31/06

**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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	267,263	30		9
10	Interest and Other Investment Income	(182)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(107)	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	(24,551)	21		18
19	Entertainment				19
20	Contributions	(1,390)	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	(586,145)	21		24
25	Fund Raising, Advertising and Promotional	(13,039)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(615,567)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (973,719)		\$	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)	137,583		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 137,583		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (836,135)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT



## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number International Village

# 0041590

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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)	
	<b>A. General Services</b>													
1	Dietary			500				4,089	1,815		(83)		6,321	1
2	Food Purchase	(107)							(1,748)				(1,855)	2
3	Housekeeping										(2,762)		(2,762)	3
4	Laundry													4
5	Heat and Other Utilities			2,283			102		203				2,588	5
6	Maintenance			3,462	5,918		67		324		(382)	1,957	11,346	6
7	Other (specify):*				856	11		699					1,566	7
8	<b>TOTAL General Services</b>	<b>(107)</b>		<b>6,245</b>	<b>6,774</b>	<b>11</b>	<b>169</b>	<b>4,788</b>	<b>594</b>		<b>(3,228)</b>	<b>1,957</b>	<b>17,203</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(6,757)						21,901			(9,709)		5,435	10
10a	Therapy							2,717					2,717	10a
11	Activities										(6)		(6)	11
12	Social Services				3,266			10,034					13,300	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				438			4,876					5,314	15
16	<b>TOTAL Health Care and Programs</b>	<b>(6,757)</b>			<b>3,704</b>			<b>39,528</b>			<b>(9,715)</b>		<b>26,760</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			2,229	4,945			37,290	3,143				47,607	17
18	Directors Fees													18
19	Professional Services	(56,824)		(239,763)			(112,073)		91				(408,569)	19
20	Fees, Subscriptions & Promotions	(17,534)		6,135			42		142				(11,215)	20
21	Clerical & General Office Expenses	(630,665)	3,475	12,818	140,552		31	10,511	4,274		(7)		(459,011)	21
22	Employee Benefits & Payroll Taxes					(15)				(1,577)	(436)		(2,028)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,872			45						3,917	24
25	Other Admin. Staff Transportation								210				210	25
26	Insurance-Prop.Liab.Malpractice			(550)			23		313				(214)	26
27	Other (specify):*				21,700			6,511	1,047				29,258	27
28	<b>TOTAL General Administration</b>	<b>(705,023)</b>	<b>3,475</b>	<b>(215,259)</b>	<b>167,197</b>	<b>(15)</b>	<b>(111,932)</b>	<b>54,312</b>	<b>9,220</b>	<b>(1,577)</b>	<b>(443)</b>		<b>(800,045)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(711,887)</b>	<b>3,475</b>	<b>(209,014)</b>	<b>177,675</b>	<b>(4)</b>	<b>(111,763)</b>	<b>98,628</b>	<b>9,814</b>	<b>(1,577)</b>	<b>(13,386)</b>	<b>1,957</b>	<b>(756,082)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number International Village

# 0041590

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	267,263	324,017	11,017			303		70			25,643	628,313	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(529,094)	665,105	25,837			866		8			2,761	165,483	32
33	Real Estate Taxes			1,887			199		72				2,158	33
34	Rent-Facility & Grounds		(816,000)	4,170									(811,830)	34
35	Rent-Equipment & Vehicles			1,117					128				1,245	35
36	Other (specify):*		23,271										23,271	36
37	<b>TOTAL Ownership</b>	<b>(261,831)</b>	<b>196,393</b>	<b>44,028</b>			<b>1,368</b>		<b>278</b>			<b>28,404</b>	<b>8,640</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(25,243)		(7,770)	(55,680)	(88,693)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>								<b>(25,243)</b>		<b>(7,770)</b>	<b>(55,680)</b>	<b>(88,693)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(973,719)</b>	<b>199,868</b>	<b>(164,986)</b>	<b>177,675</b>	<b>(4)</b>	<b>(110,395)</b>	<b>98,628</b>	<b>(15,151)</b>	<b>(1,577)</b>	<b>(21,156)</b>	<b>(25,319)</b>	<b>(836,135)</b>	<b>45</b>

**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	\$ 816,000	Highlander Care Center LLC	100.00%	\$	(816,000)	1
2	V	21 Bank Service Charges		Highlander Care Center LLC	100.00%	2,100	2,100	2
3	V	21 Trust Fees		Highlander Care Center LLC	100.00%	190	190	3
4	V	21 Filing Fees		Highlander Care Center LLC	100.00%	250	250	4
5	V	21 Miscellaneous		Highlander Care Center LLC	100.00%	935	935	5
6	V	30 Depreciation		Highlander Care Center LLC	100.00%	324,017	324,017	6
7	V	36 Amortization		Highlander Care Center LLC	100.00%	23,271	23,271	7
8	V	32 Interest		Highlander Care Center LLC	100.00%	665,105	665,105	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 816,000			\$ 1,015,868	\$ * 199,868	14

\* 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: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 500	500	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,283	2,283	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	3,462	3,462	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,229	2,229	19	
20	V	19	Professional Fees	256,671	Care Centers, Inc.	100.00%	16,908	(239,763)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	6,135	6,135	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	12,818	12,818	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,872	3,872	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(550)	(550)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	11,017	11,017	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	25,837	25,837	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,887	1,887	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,170	4,170	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,117	1,117	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			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			\$ 256,671			\$ 91,685	\$ * (164,986)	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		Care Centers, Inc.	100.00%	5,918	5,918	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	856	856	16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	3,266	3,266	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	438	438	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	4,945	4,945	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	140,552	140,552	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	21,700	21,700	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			\$			\$ 177,675	\$ * 177,675	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	06 Maintenance Salary	99	Care Centers, Inc.	100.00%	99		15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	11	11	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V	17 Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21 Office Salary		Care Centers, Inc.	100.00%			22
23	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			23
24	V							24
25	V	22 Employee Benefits	15				(15)	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		\$ 114			\$ 110	\$ *	(4) 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	19	Professional Fees	\$ 112,512	Care Centers Clinical, Inc.	100.00%	\$ 439	\$ (112,073)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	42	42	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	31	31	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	45	45	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	303	303	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	866	866	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	102	102	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	67	67	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	23	23	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	199	199	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		\$ 112,512				\$ 2,117	\$ * (110,395)	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	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 4,089	\$ 4,089	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	699	699	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	21,901	21,901	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	2,717	2,717	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	10,034	10,034	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	4,876	4,876	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	37,290	37,290	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	10,511	10,511	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	6,511	6,511	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		\$				\$ 98,628	\$ * 98,628	39

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems	100.00%	\$ 1,815	\$ 1,815	15	
16	V	02	Food	3,809	Care Centers Health Systems	100.00%	2,061	(1,748)	16	
17	V	05	Utilities		Care Centers Health Systems	100.00%	203	203	17	
18	V	06	Maintenance		Care Centers Health Systems	100.00%	324	324	18	
19	V	17	Administration		Care Centers Health Systems	100.00%	475	475	19	
20	V	19	Professional Fees		Care Centers Health Systems	100.00%	91	91	20	
21	V	20	Dues & Subscriptions		Care Centers Health Systems	100.00%	142	142	21	
22	V	21	Office & Clerical		Care Centers Health Systems	100.00%	299	299	22	
23	V	25	Auto Expenses		Care Centers Health Systems	100.00%	210	210	23	
24	V	26	Insurance		Care Centers Health Systems	100.00%	313	313	24	
25	V	30	Depreciation		Care Centers Health Systems	100.00%	70	70	25	
26	V	32	Interest Expense		Care Centers Health Systems	100.00%	8	8	26	
27	V	33	Real Estate Taxes		Care Centers Health Systems	100.00%	72	72	27	
28	V	35	Rent - Equipment & Auto		Care Centers Health Systems	100.00%	128	128	28	
29	V	39	Ancillary Enteral Supplies	44,782	Care Centers Health Systems	100.00%	19,539	(25,243)	29	
30	V	17	Administrative-Salary		Care Centers Health Systems	100.00%	2,668	2,668	30	
31	V	21	Office & Clerical-Salary		Care Centers Health Systems	100.00%	3,975	3,975	31	
32	V	27	Emp. Ben. - Gen. Admin.		Care Centers Health Systems	100.00%	1,047	1,047	32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 48,591			\$ 33,440	\$ * (15,151)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 77,884	\$ 77,884	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	79,461	CCS EMPLOYEE BENEFIT GROUP	100.00%		(79,461)	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			\$ 79,461			\$ 77,884	\$ * (1,577)	39

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	\$ 1,026	Xcel Supply, LLC	100.00%	\$ 943	\$ (83)	15
16	V	03 Housekeeping	34,060	Xcel Supply, LLC	100.00%	31,297	(2,762)	16
17	V	04 Laundry		Xcel Supply, LLC	100.00%			17
18	V	06 Repairs & Maintenance	4,714	Xcel Supply, LLC	100.00%	4,332	(382)	18
19	V	10 Nursing	119,722	Xcel Supply, LLC	100.00%	110,013	(9,709)	19
20	V	11 Activities	75	Xcel Supply, LLC	100.00%	69	(6)	20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office	90	Xcel Supply, LLC	100.00%	82	(7)	23
24	V	22 Employee Benefits	5,373	Xcel Supply, LLC	100.00%	4,937	(436)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	95,810	Xcel Supply, LLC	100.00%	88,040	(7,770)	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		\$ 260,869			\$ 239,713	\$ * (21,156)	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 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 1,957	\$ 1,957	15
16	V	30 Depreciation		Vent Lease, LLC.	100.00%	25,643	25,643	16
17	V	32 Interest		Vent Lease, LLC.	100.00%	2,761	2,761	17
18	V	39 Vent/Ancillary Reimbursement	55,680	Vent Lease, LLC.	100.00%		(55,680)	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		\$ 55,680			\$ 30,361	\$ * (25,319)	39

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

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.24	2.69%	Alloc. Sal.	\$ 2,028	17-7	1
2	Gale Rothner	Relative	Administrative	0.00%	See Attached	1.30	3.71%	Alloc. Sal.	2,897	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.04	3.71%	Alloc. Sal.	4,962	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,887		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: 01/01/06 Ending: 12/31/06

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: 01/01/06

Ending: 12/31/06

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	1,592,658	31	\$ 13,468	\$ 59,159	\$ 500	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	59,159	2,283	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	59,159	3,462	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	59,159	2,229	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	59,159	16,908	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	59,159	6,135	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	59,159	12,818	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	59,159	3,872	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	59,159	(550)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	59,159	11,017	11
12	32	Interest	Patient Days	1,592,658	31	695,586	59,159	25,837	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	59,159	1,887	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	59,159	4,170	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	59,159	1,117	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 91,685	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	Patient Days	1,592,658	31	159,318	159,318	59,159	5,918	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		59,159	856	2
3	10	Nursing Salary	Patient Days	1,592,658	31			59,159		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			59,159		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	59,159	3,266	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		59,159	438	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	59,159	4,945	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	59,159	140,552	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		59,159	21,700	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					\$ 4,783,299	\$ 4,164,272		\$ 177,675	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Allocation	26	366,540	366,540		99	1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			11	2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249			8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744				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				\$ 916,329	\$ 784,790		\$ 110	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Clinical, 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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 59,159	\$ 439	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	59,159	42	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	59,159	31	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	59,159	45	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	59,159	303	5
6	32	Interest	Patient Days	1,592,658	30	23,321	59,159	866	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	59,159	102	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	59,159	67	8
9	26	Insurance	Patient Days	1,592,658	30	623	59,159	23	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	59,159	199	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					\$ 57,020	\$	\$ 2,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Clinical, 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	1,592,658	30	110,093	110,093	59,159	4,089	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	59,159	699	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		59,159	21,901	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	59,159	2,717	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	59,159	10,034	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		59,159	4,876	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		59,159	37,290	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	59,159	10,511	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		59,159	6,511	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					\$ 2,655,265	\$ 755,172		\$ 98,628	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Health Systems  
 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	2,455,454	33	91,698	48,591	1,815	1
2	02	Food	Billable Income	2,455,454	33	104,128	48,591	2,061	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	48,591	203	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	48,591	324	4
5	17	Administration	Billable Income	2,455,454	33	24,000	48,591	475	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	48,591	91	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	48,591	142	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	48,591	299	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	48,591	210	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	48,591	313	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	48,591	70	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	48,591	8	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	48,591	72	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	48,591	128	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	48,591	19,539	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	48,591	2,668	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	3,975	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	1,047	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 33,440	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 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		\$	\$		\$ 77,884	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				\$	\$		\$ 77,884	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Supply, LLC  
 Street Address 2201 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			\$	\$		943	1
2	03	Housekeeping						31,297	2
3	04	Laundry							3
4	06	Repairs & Maintenance						4,332	4
5	10	Nursing						110,013	5
6	11	Activities						69	6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom							8
9	21	Clerical & General Office						82	9
10	22	Employee Benefits						4,937	10
11	24	Seminars & Education							11
12	39	Ancillary						88,040	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				\$	\$		239,713	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

# 0041590

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 55,680	\$ 1,957	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	55,680	25,643	2
3	32	Interest	Direct Billing	868,537	31	43,063	55,680	2,761	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 30,361	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Corus Bank		X	Mortgage			\$	\$ 1,999,984		\$ 170,693	1									
2	Eric Rothner	X								25,474	2									
3	Related Party Interest									(25,474)	3									
4											4									
5	See Supplemental Schedule										5									
<b>Working Capital</b>																				
6	Diawa		X	Line of Credit				7,857,483		638,333	6									
7	Shareholder Loan	X		Working Capital				600,000		34,500	7									
8	See Supplemental Schedule							6,935,759		(5,028)	8									
9	<b>TOTAL Facility Related</b>						\$	\$ 17,393,226		\$ 838,498	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(182)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		(182)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 17,393,226		\$ 838,316	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

International Village

# 0041590

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

	1	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	<b>TOTAL Long-Term</b>											7						
<b>Working Capital</b>																		
8	South Shore (Related Party)	X					\$	\$ 2,768,667			\$ 187,194	8						
9	Applewood (Related Party)	X						4,167,092			281,744	9						
10	Allocated From CareCenters		X								26,711	10						
11	Allocated From Vent Lease		X								2,761	11						
12	Less: Shareholder Interest	X									(34,500)	12						
13	Less: Related Party Interest	X									(468,938)	13						
14	<b>TOTAL Working Capital</b>							6,935,759			(5,028)	14						
<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>											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.)

\*\* 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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 317,504	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.)		\$ 307,630	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (9,874)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 320,739	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 3,500	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 314,365	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	357,200	8
	2002	304,867	9
	2003	295,822	10
	2004	302,394	11
	2005	305,472	12
<b>2006 Accrual= \$305,472*1.05 = \$320,739</b>			
<b>Allocated From Care Centers \$2,158</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 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 2005 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 2005.

(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>221,548.14</u>	\$ <u>221,548.14</u>
2. <u>20-07-104-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>911.27</u>	\$ <u>911.27</u>
3. <u>20-07-104-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>784.83</u>	\$ <u>784.83</u>
4. <u>20-07-104-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>279.25</u>	\$ <u>279.25</u>
5. <u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>73,455.89</u>	\$ <u>73,455.89</u>
6. <u>20-07-104-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,582.77</u>	\$ <u>7,582.77</u>
7. <u>20-07-104-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>910.31</u>	\$ <u>910.31</u>
8. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>1,914.29</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>421,860.93</u>	\$ <u>307,386.75</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

(A)	(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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**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 Care Centers</u>			<u>13,488</u>	2
3	<b>TOTALS</b>	<b>115,710</b>		<b>\$ 915,021</b>	<b>3</b>

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**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
<b>Improvement Type**</b>											
9	Various			2000	169,034		20	8,450	8,450	48,889	9
10	Various			2001	50,660		20	2,537	2,537	14,230	10
11	Various			2002	33,110		20	3,332	3,332	15,550	11
12											12
13											13
14											14
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31											31
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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

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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
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64								64
65								65
66								66
67		10,857,112	319,693		364,436	44,743	2,280,463	67
68		52,931	1,500		2,194	694	8,734	68
69			77,075			(77,075)		69
70		\$ 11,162,847	\$ 398,268		\$ 380,949	\$ (17,319)	\$ 2,367,866	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 11,162,847	\$ 398,268		\$ 380,949	\$ (17,319)	\$ 2,367,866	1
2	6' Chain Link Fence	2003	2,295		20	115	115	459	2
3	Carpet Cleaning	2003	1,072		20	107	107	420	3
4	Corner Guards	2003	1,031		20	52	52	202	4
5	Electrical Work	2003	5,250		20	525	525	2,013	5
6	Electrical Work	2003	5,540		20	554	554	2,124	6
7	6' Double Swing Gate	2003	1,098		20	110	110	421	7
8	Electrical Work	2003	2,390		20	239	239	896	8
9	Shower Equip & Repairs	2003	1,858		20	93	93	341	9
10	Wiring Repair	2003	556		20	56	56	195	10
11	Ceiling Mounts	2003	1,127		20	56	56	193	11
12	Humidity-Heat System	2003	500		20	50	50	167	12
13	Installment On Heat System	2003	500		20	50	50	163	13
14	Installment On Heat System	2003	500		20	50	50	158	14
15	Installment On Heat System	2003	548		20	55	55	174	15
16	Repair Broken Main Line	2004	1,550		20	155	155	336	16
17	Tile & Carpeting Work	2004	2,502		20	250	250	542	17
18	Tile For 2Nd Fl	2004	2,014		20	201	201	436	18
19	Replace Tempering Valve	2004	657		20	66	66	137	19
20	Tel System Repair	2004	584		20	117	117	350	20
21	Electric Door Opener	2004	5,223		20	1,045	1,045	2,699	21
22	Roof Exhauster	2004	1,392		20	278	278	673	22
23	Door Keypad - Timer	2004	2,245		20	449	449	1,048	23
24	Frozen Pipes Repair	2004	682		20	68	68	205	24
25	Roof Work	2004	3,200		20	320	320	693	25
26	Relocating Water Pumps	2004	580		20	58	58	164	26
27	Repair Elevator	2004	1,559		20	156	156	429	27
28	New Sidewalk	2004	1,450		20	145	145	338	28
29	Reconstruct Elevator	2004	13,100		20	1,310	1,310	3,057	29
30	Door Alarms	2004	570		20	29	29	67	30
31	Showers - Posigrip	2004	825		20	41	41	96	31
32	Camera System	2005	16,128		20	3,226	3,226	5,645	32
33	Filters	2005	2,680		20	268	268	424	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,244,053	\$ 398,268		\$ 391,243	\$ (7,025)	\$ 2,393,131	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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**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		\$ 11,244,053	\$ 398,268		\$ 391,243	\$ (7,025)	\$ 2,393,131	1
2	Valves	2005	4,023		20	402	402	603	2
3	Settlement On Issues	2005	5,493		20	549	549	732	3
4	Hvac Repair	2005	1,635		20	82	82	95	4
5	Hvac Repair	2005	1,584		20	79	79	119	5
6	Carpetmates/Carpeting	2006	7,233		20	301	301	301	6
7	Sgp Services Rooftop Blinder	2006	3,200		20	320	320	320	7
8	Opened Sewer Line	2006	6,580		20	274	274	274	8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

SEE ACCOUNTANTS' COMPILATION REPORT

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
2								2
3								3
4								4
5								5
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
2									2
3									3
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
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3									3
4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
2								2
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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**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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
2									2
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32									32
33									33
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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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1
2								2
3								3
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	34

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**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 12K, Carried Forward	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	1	
2									2
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4									4
5									5
6									6
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31									31
32									32
33									33
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Ending:

12/31/06

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 12L, Carried Forward	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575		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)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575		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:

01/01/06

Ending:

12/31/06

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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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:

01/01/06

Ending:

12/31/06

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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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:

01/01/06

Ending:

12/31/06

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 12O, Carried Forward		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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)		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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:

01/01/06

Ending:

12/31/06

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		\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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)	\$ 11,273,801	\$ 398,268		\$ 393,250	\$ (5,018)	\$ 2,395,575	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:

01/01/06

Ending:

12/31/06

**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	\$ 9,618,909	\$ 246,639	39	\$ 360,783	\$ 114,144	\$ 2,254,894	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Allocation From Highlander Care Center		2000	2000	1,238,203	73,054	20	3,653	(69,401)	25,569	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:

01/01/06

Ending:

12/31/06

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)	\$ 10,857,112	\$ 319,693		\$ 364,436	\$ 44,743	\$ 2,280,463	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

**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	Allocated From CareCenters Health Systems		2002	2002	\$ 624	\$ 16	39	\$ 16	\$	\$ 69	4
5	Allocated From Care Centers, Inc. 2201 Main		2002	2002	16,248	417	39	417		1,788	5
6	Allocated From Care Centers Clinical		2002	2002	1,714	44	39	44		189	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated From CareCenters Health Systems			2002	515	21	20	26	5	116	9
10	Allocated From CareCenters Health Systems			2003	607	12	20	30	18	106	10
11	Allocated From CareCenters Health Systems			2005	30	1	20	2	1	2	11
12											12
13	Allocated From Care Centers, Inc.2201 Main			2002	13,422	558	20	671	113	3,020	13
14	Allocated From Care Centers, Inc.2201 Main			2003	15,818	301	20	791	490	2,768	14
15	Allocated From Care Centers, Inc.2201 Main			2005	786	35	20	39	4	59	15
16											16
17	Allocated From Care Centers Clinical			2002	1,416	59	20	71	12	319	17
18	Allocated From Care Centers Clinical			2003	1,668	32	20	83	51	292	18
19	Allocated From Care Centers Clinical			2005	83	4	20	4		6	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:

01/01/06

Ending:

12/31/06

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		52,931	1,500		2,194	694	8,734	

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: 01/01/06 Ending: 12/31/06

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	\$ 588,855	\$ 39,370	\$ 83,422	\$ 44,052	10	\$ 350,396	71
72	Current Year Purchases	361	54	54		10	54	72
73	Fully Depreciated Assets	2,283,332		226,361	226,361	10	1,604,253	73
74								74
75	TOTALS	\$ 2,872,548	\$ 39,424	\$ 309,837	\$ 270,413		\$ 1,954,703	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		Allocated From Care Centers, Inc.		\$ 25,090	\$	\$ 1,957	\$ 1,957	5	\$ 18,874	76
77		Allocated From Care Centers, Inc.		1,621	324	235	(89)	5	235	77
78		Allocated From Care Centers, Clinical		1,625	110	110		5	110	78
79										79
80	TOTALS			\$ 28,336	\$ 434	\$ 2,302	\$ 1,868		\$ 19,219	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)	\$ 15,089,706	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 705,389	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 267,263	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,369,497	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				4,170			6
7	TOTAL				\$ 4,170			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 8,748 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 230,722	\$		\$ 230,722	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			49,294			49,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			190,912			190,912	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				352,099		352,099	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>			183,961		58,200	261,771		503,932	13
14	<b>TOTAL</b>			\$ 183,961		\$ 529,128	\$ 613,870		\$ 1,326,959	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: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,000	\$ 167,026	1
2	Cash-Patient Deposits	44,154	44,154	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,259,556	3,259,556	3
4	Supply Inventory (priced at )		9,065	4
5	Short-Term Investments			5
6	Prepaid Insurance	149,915	149,915	6
7	Other Prepaid Expenses	8,830	8,830	7
8	Accounts Receivable (owners or related parties)	697,650	1	8
9	Other(specify): <u>See Attached Schedule</u>	151,905	190,992	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,313,010	\$ 3,829,539	10
	<b>B. Long-Term Assets</b>			
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	309,921	1,548,124	15
16	Equipment, at Historical Cost	492,327	2,805,987	16
17	Accumulated Depreciation (book methods)	(518,872)	(4,999,024)	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>		175,504	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 283,376	\$ 10,306,331	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,596,386	\$ 14,135,870	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,382,729	\$ 1,382,729	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,681	42,681	28
29	Short-Term Notes Payable	7,857,483	7,857,483	29
30	Accrued Salaries Payable	145,304	145,304	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,571	12,571	31
32	Accrued Real Estate Taxes(Sch.IX-B)	320,739	320,739	32
33	Accrued Interest Payable	248,406	264,336	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	2,174	3,768,682	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 10,012,087	\$ 13,794,525	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	600,000	600,000	39
40	Mortgage Payable		8,935,743	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 600,000	\$ 9,535,743	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 10,612,087	\$ 23,330,268	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (6,015,701)	\$ (9,194,398)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,596,386	\$ 14,135,870	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,123,906)	1
2	Restatements (describe):		2
3	Depreciation (2004 & 2005)	1,932	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,121,974)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,893,727)	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)	\$ (1,893,727)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (6,015,701)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590Report Period Beginning: 01/01/06Ending: 12/31/06**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,447,051	1
2	Discounts and Allowances for all Levels	(2,451,582)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,995,469	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,076,369	6
7	Oxygen	10,636	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,087,005	8
<b>C. Other Operating Revenue</b>			
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	341,639	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	125,781	19
20	Radiology and X-Ray	13,460	20
21	Other Medical Services	49,878	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 530,758	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	182	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 182	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	14,732	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,732	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,628,146	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,629,514	31
32	Health Care	4,022,543	32
33	General Administration	2,541,384	33
<b>B. Capital Expense</b>			
34	Ownership	1,882,118	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,326,959	35
36	Provider Participation Fee	119,355	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,521,873	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,893,727)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,893,727)	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:

01/01/06

Ending:

12/31/06

**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	1,936	2,676	\$ 111,024	\$ 41.49	1
2	Assistant Director of Nursing	1,728	2,683	84,166	31.37	2
3	Registered Nurses	15,191	16,934	480,611	28.38	3
4	Licensed Practical Nurses	45,744	49,401	1,188,677	24.06	4
5	CNAs & Orderlies	103,249	112,831	1,114,377	9.88	5
6	CNA Trainees					6
7	Licensed Therapist	6,995	7,895	183,961	23.30	7
8	Rehab/Therapy Aides	11,334	12,393	172,758	13.94	8
9	Activity Director	1,913	2,171	32,746	15.08	9
10	Activity Assistants	12,878	13,957	116,064	8.32	10
11	Social Service Workers	10,473	12,409	164,634	13.27	11
12	Dietician	2,057	2,212	32,548	14.71	12
13	Food Service Supervisor	1,934	2,162	38,508	17.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,791	5,111	50,726	9.92	15
16	Dishwashers	21,520	23,078	181,723	7.87	16
17	Maintenance Workers	5,199	5,781	100,261	17.34	17
18	Housekeepers	27,917	30,633	244,597	7.98	18
19	Laundry	6,097	6,736	56,181	8.34	19
20	Administrator	1,984	2,079	80,840	38.88	20
21	Assistant Administrator	1,571	1,606	40,200	25.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,613	9,213	113,347	12.30	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	2,769	3,248	40,184	12.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,950	2,217	24,845	11.21	33
34	TOTAL (lines 1 - 33)	297,843	327,426	\$ 4,652,978 *	\$ 14.21	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	503	\$ 21,580	01-03	35
36	Medical Director	Monthly	66,250	09-03	36
37	Medical Records Consultant	13	455	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,665	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1,907	77,053	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,649	11-03	44
45	Social Service Consultant	39	2,093	12-03	45
46	Other(specify) <u>Therapy Consultant</u>	24	1,692	10a-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,537	\$ 174,437		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 560	10-03	50
51	Licensed Practical Nurses	4,132	146,483	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,148	\$ 147,043		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number International Village

Report Period Beginning: 01/01/06 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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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

Facility Name &amp; ID Number International Village

**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. ILCLTC \$12,072; IL Assoc of HC \$3,706
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,889 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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