		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0029660

Facility Name: Mayfield Care Center

Address: 5905 West Washington (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 261-7074 **Fax #** (773) 261-2116

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1985

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,101		5,247	24,348	8
9	SNF/PED					9
10	ICF	19,299	366		19,665	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,400	366	5,247	44,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.30%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 156 and days of care provided 4,455

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	220,318	48,495	20,037	288,850		288,850		288,850			1
2	Food Purchase		235,683		235,683	(44,366)	191,317	(2,755)	188,562			2
3	Housekeeping	258,392	93,294		351,686		351,686	592	352,278			3
4	Laundry	86,375	22,112		108,487		108,487		108,487			4
5	Heat and Other Utilities			155,433	155,433		155,433	2,216	157,649			5
6	Maintenance	97,304	30,890	42,703	170,897		170,897	12,755	183,652			6
7	Other (specify):*											7
8	TOTAL General Services	662,389	430,474	218,173	1,311,036	(44,366)	1,266,670	12,808	1,279,478			8
	B. Health Care and Programs											
9	Medical Director			52,900	52,900		52,900		52,900			9
10	Nursing and Medical Records	2,713,415	167,769	16,416	2,897,600		2,897,600	(17)	2,897,583			10
10a	Therapy	145,937		1,310	147,247		147,247		147,247			10a
11	Activities	95,726	11,238		106,964		106,964		106,964			11
12	Social Services	170,920		3,416	174,336		174,336		174,336			12
13	CNA Training											13
14	Program Transportation			240	240		240		240			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,125,998	179,007	74,282	3,379,287		3,379,287	(17)	3,379,270			16
	C. General Administration											
17	Administrative	291,239		230,544	521,783		521,783	(155,027)	366,756			17
18	Directors Fees											18
19	Professional Services			430,762	430,762	(3,000)	427,762	(204,554)	223,208			19
20	Dues, Fees, Subscriptions & Promotions			105,523	105,523		105,523	(87,242)	18,281			20
21	Clerical & General Office Expenses	42,612	46,027	442,168	530,807		530,807	(339,246)	191,561			21
22	Employee Benefits & Payroll Taxes			698,572	698,572	44,366	742,938		742,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,798	1,798		1,798	312	2,110			24
25	Other Admin. Staff Transportation			1,880	1,880		1,880	(309)	1,571			25
26	Insurance-Prop.Liab.Malpractice			76,774	76,774		76,774	142,075	218,849			26
27	Other (specify):*							35,431	35,431			27
28	TOTAL General Administration	333,851	46,027	1,988,021	2,367,899	41,366	2,409,265	(608,560)	1,800,705			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,122,238	655,508	2,280,476	7,058,222	(3,000)	7,055,222	(595,770)	6,459,452			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center #0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			16,063	16,063		16,063	194,508	210,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,816	37,816		37,816	274,515	312,331			32
33	Real Estate Taxes			982	982	3,000	3,982	187,895	191,877			33
34	Rent-Facility & Grounds			672,000	672,000		672,000	(672,000)	(0)			34
35	Rent-Equipment & Vehicles			12,935	12,935		12,935	(12,921)	14			35
36	Other (specify):*							25,467	25,467			36
37	TOTAL Ownership			739,796	739,796	3,000	742,796	(2,536)	740,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		256,069	828,889	1,084,958		1,084,958		1,084,958			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*	128,864		32,107	160,971		160,971	(160,971)				43
44	TOTAL Special Cost Centers	128,864	256,069	946,406	1,331,339		1,331,339	(160,971)	1,170,368			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,251,102	911,577	3,966,678	9,129,357		9,129,357	(759,277)	8,370,080			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 Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,934)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	65,601	30		9
10	Interest and Other Investment Income	(17,901)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(51,760)	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	(407,646)	21		24
25	Fund Raising, Advertising and Promotional	(29,655)	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	(215,743)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (660,057)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(99,219)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (99,219)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (759,277)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (2,736)	02	1
2	Marketing Salary	(128,864)	43	2
3	Marketing Consultant	(32,107)	43	3
4	Annual Fees	(875)	20	4
5	Bank Charges	(899)	21	5
6	Building Company Legal & Professional	(15,424)	19	6
7	Building Company Annual Report	(255)	20	7
8	Building Company Accounting	(11,500)	19	8
9	Building Company Amortization	(1,598)	31	9
10	Election Income	(550)	21	10
11	Jury Duty- Nursing Staff	(17)	10	11
12	Additional R&M	12,666	06	12
13	Non-Allowable Legal	(9,730)	19	13
14	Non-Allowable Travel	(313)	25	14
15	COPE Dues	(5,606)	20	15
16	Non-Allowable Auto Lease	(12,935)	35	16
17	Non-Allowable Accounting Fee	(5,000)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(215,743)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Mayfield Care Center **#** 0029660 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(2,755)											(2,755)	2
3	Housekeeping			581		11							592	3
4	Laundry													4
5	Heat and Other Utilities			1,031		1,185							2,216	5
6	Maintenance	9,732		2,520		503							12,755	6
7	Other (specify):*													7
8	**TOTAL General Services**	6,977		4,132		1,699							12,808	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)											(17)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(17)											(17)	16
	C. General Administration													
17	Administrative			46,954	(202,379)	398							(155,027)	17
18	Directors Fees													18
19	Professional Services	(41,654)	26,924	(189,882)		58							(204,554)	19
20	Fees, Subscriptions & Promotions	(88,151)	255	602	18	34							(87,242)	20
21	Clerical & General Office Expenses	(409,095)		69,555	279	15							(339,246)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			312									312	24
25	Other Admin. Staff Transportation	(313)		4									(309)	25
26	Insurance-Prop.Liab.Malpractice		141,687	229		159							142,075	26
27	Other (specify):*			32,211	3,220								35,431	27
28	**TOTAL General Administration**	(539,213)	168,866	(40,015)	(198,862)	664							(608,560)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(532,254)	168,866	(35,883)	(198,862)	2,363							(595,770)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	65,601	125,697	3,040		170							194,508	30
31	Amortization of Pre-Op. & Org.	(1,598)	1,598											31
32	Interest	(17,901)	290,318	259		1,839							274,515	32
33	Real Estate Taxes		185,901			1,994							187,895	33
34	Rent-Facility & Grounds		(672,000)	8,713		(8,713)							(672,000)	34
35	Rent-Equipment & Vehicles	(12,935)		14									(12,921)	35
36	Other (specify):*		25,467										25,467	36
37	**TOTAL Ownership**	33,167	(43,019)	12,026		(4,710)							(2,536)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(160,971)											(160,971)	43
44	**TOTAL Special Cost Centers**	(160,971)											(160,971)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(660,057)	125,847	(23,857)	(198,862)	(2,347)							(759,277)	45

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		
				Mayfield Building Limited		Building Co.

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 672,000	Mayfield Building Limited	100.00%	$	$ (672,000)	1
2	V	32	Interest	249	Mayfield Building Limited	100.00%	290,567	290,318	2
3	V	36	Mortgage Insurance		Mayfield Building Limited	100.00%	25,467	25,467	3
4	V	19	Legal & Professional Expense		Mayfield Building Limited	100.00%	15,424	15,424	4
5	V	20	Annual Report		Mayfield Building Limited	100.00%	255	255	5
6	V	19	Accounting Fees		Mayfield Building Limited	100.00%	11,500	11,500	6
7	V	30	Depreciation		Mayfield Building Limited	100.00%	125,697	125,697	7
8	V	31	Amortization		Mayfield Building Limited	100.00%	1,598	1,598	8
9	V	33	Real Estate Taxes		Mayfield Building Limited	100.00%	185,901	185,901	9
10	V	26	Insurance Expense		Mayfield Building Limited	100.00%	141,687	141,687	10
11	V								11
12	V								12
13	V								13
14	Total			$ 672,249			$ 798,096	$ * 125,847	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 581	$ 581	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,031	1,031	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,520	2,520	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	46,954	46,954	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,062	1,062	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	602	602	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	69,555	69,555	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	312	312	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	4	4	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	229	229	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	32,211	32,211	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	3,040	3,040	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	259	259	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	8,713	8,713	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	14	14	30
31	V	19	HOME OFFICE	190,944	MANAGCARE, INC.	100.00%		(190,944)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 190,944			$ 167,087	$ * (23,857)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 28,165	$ 28,165	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	18	18	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	279	279	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	3,220	3,220	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V	32	INVESTMENT		INTERCARE, LTD. C/O MANAGCARE	100.00%			21
22	V	35	EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%			22
23	V								23
24	V	17	MANAGEMENT FEES	230,544	INTERCARE, LTD. C/O MANAGCARE	100.00%		(230,544)	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			$ 230,544			$ 31,682	$ * (198,862)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MAZEL MANAGEMENT	100.00%	$ 11	$ 11	15
16	V	5	UTILITIES		MAZEL MANAGEMENT		1,185	1,185	16
17	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		503	503	17
18	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		398	398	19
20	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		58	58	20
21	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		34	34	21
22	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		15	15	22
23	V	26	INSURANCE		MAZEL MANAGEMENT		159	159	23
24	V	30	DEPRECIATION		MAZEL MANAGEMENT		170	170	24
25	V	31	AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		1,839	1,839	26
27	V	33	REAL ESTATE TAXES				1,994	1,994	27
28	V								28
29	V	34	RENT	8,713				(8,713)	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			$ 8,713			$ 6,366	$ * (2,347)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Mgmt/Admin	69.38%	See Attached	4.22	14.07%	Sal./Al.Sal	$ 43,165	17-1, 17-7	1
2	Yisroel Davis	Shareholder	Administrative	0.56%	See Attached	40.00	100.00%	Salary	76,058	17-1	2
3	Moshe Wolf	Relative	Administrative	0.00%	See Attached	0.85	1.78%	Alloc.Sal/Fees	5,556	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	7.13	16.20%	Alloc. Salary	19,703	17-7	4
5	Moshe Davis	Shareholder	Mgmt/Admin	0.56%	See Attached	44.00	91.67%	Salary	192,801	17-1	5
6											6
7											7
8	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										8
9	IL Dept. of HFS.										9
10											10
11											11
12											12
13								TOTAL	$ 337,283		13

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	259,131	3	$ 3,420	$	44,013	$ 581	1
2	5	UTILITIES	PATIENT DAYS	259,131	3	6,068		44,013	1,031	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	259,131	3	14,839		44,013	2,520	3
4	10	NURSING SALARIES	PATIENT DAYS	259,131	3			44,013		4
5	17	ADMINISTRATIVE	PATIENT DAYS	259,131	3	276,447	276,447	44,013	46,954	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	259,131	3	6,250		44,013	1,062	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	259,131	3	3,547		44,013	602	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	259,131	3	409,513	341,493	44,013	69,555	8
9	24	SEMINARS	PATIENT DAYS	259,131	3	1,835		44,013	312	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	259,131	3	22		44,013	4	10
11	26	INSURANCE	PATIENT DAYS	259,131	3	1,347		44,013	229	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	259,131	3	189,648		44,013	32,211	12
13	30	DEPRECIATION	PATIENT DAYS	259,131	3	17,897		44,013	3,040	13
14	32	INTEREST EXPENSE	PATIENT DAYS	259,131	3	1,526		44,013	259	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	259,131	3	51,300		44,013	8,713	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	259,131	3	81		44,013	14	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 983,740	$ 617,940		$ 167,087	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	18	4	$ 120,000	$ 120,000	4	$ 28,165	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	18	4			4		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	75		4	18	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	1,189		4	279	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	13,719		4	3,220	5
6	30	DEPRECIATION	AVG. HOURS WORKED	18	4			4		6
7	32	INVESTMENT	AVG. HOURS WORKED	18	4			4		7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED	18	4			4		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					$ 134,983	$ 120,000		$ 31,682	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MNGCR. PATIENT DAYS	259,131	3	$ 62	$	44,013	$ 11	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	259,131	3	6,974		44,013	1,185	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	259,131	3	2,962		44,013	503	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	259,131	3			44,013		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	259,131	3	2,340		44,013	398	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	259,131	3	344		44,013	58	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	259,131	3	198		44,013	34	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	259,131	3	90		44,013	15	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	259,131	3	938		44,013	159	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	259,131	3	1,002		44,013	170	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	259,131	3			44,013		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	259,131	3	10,826		44,013	1,839	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	259,131	3	11,741		44,013	1,994	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					$ 37,477	$		$ 6,366	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Greystone/Heartland		X	Mortgage			$	$ 5,107,416			$ 290,567	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				800,000			34,015	6
7	Allocated From Mazel Mgmt		X								1,839	7
8	See Supplemental Schedule										259	8
9	TOTAL Facility Related						$	$ 5,907,416			$ 326,680	9
	B. Non-Facility Related*											
10	Interest Income		X								(17,901)	10
11	Interest Income-Bldg Co.		X								(249)	11
12	Miscellaneous Interest Expense		X								3,801	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (14,349)	14
15	TOTALS (line 9+line14)						$	$ 5,907,416			$ 312,331	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 25,467 **Line #** 36

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

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 Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From Managcare		X				$	$			$ 259	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										259	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.	$	55,200	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.)	$	126,886	2
3. Under or (over) accrual (line 2 minus line 1).	$	71,686	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	117,191	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	3,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	191,877	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	60,049	8
	2006	55,314	9
	2007	54,724	10
	2008	55,272	11
	2009	124,892	12

2010 Accrual= $124,892 X .94 = $117,191 (Rounded)

Allocated From Mazel Management= $1,994

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-08-419-002-0000	Long Term Care Property	$ 982.40	$ 982.40
2.	16-08-419-003-0000	Long Term Care Property	$ 27,994.60	$ 27,994.60
3.	16-08-419-004-0000	Long Term Care Property	$ 41,752.38	$ 41,752.38
4.	16-08-419-005-0000	Long Term Care Property	$ 28,831.07	$ 28,831.07
5.	16-08-419-006-0000	Long Term Care Property	$ 20,107.74	$ 20,107.74
6.	16-08-419-007-0000	Long Term Care Property	$ 5,224.25	$ 5,224.25
7.	See Attached	Allocation From Managcare/Mazel	$ 51,712.83	$ 2,013.70
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 176,605.27	$ 126,906.14

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

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 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,500 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 4

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 168,991	1
2					2
3	TOTALS			$ 168,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	11,950		20			11,898	9
10	Various			1986	24,199		20			24,077	10
11	Various			1987	12,137		20	392	392	9,238	11
12	Various			1988	38,957		20	1,257	1,257	28,383	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	1,229	1,229	35,294	14
15	Various			1991	34,073		20	1,704	1,704	32,800	15
16	Various			1992	1,200		20	60	60	1,130	16
17	Various			1993	6,071		20	304	304	5,275	17
18	Various			1994	24,281		20	1,214	1,214	19,700	18
19	Various			1995	1,467		20	73	73	1,130	19
20	Various			1996	64,140		20	3,207	3,207	46,636	20
21	Various			1997	15,923		20	796	796	10,792	21
22	Various			1998	966,314		20	48,316	48,316	587,926	22
23	Various			1999	137,374		20	6,869	6,869	79,995	23
24	Various			2000	43,701		20	1,768	1,768	31,006	24
25	Various			2001	9,572		20	715	715	6,912	25
26	Various			2002	14,269		20	1,427	1,427	12,354	26
27	Various			2003	3,119		20	212	212	1,786	27
28	Various			2004	32,093		20	1,687	1,687	16,241	28
29	Various			2005	14,586		20	1,491	1,491	8,607	29
30	Various			2006	8,163		20	848	848	3,750	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,595,648	44,572		79,782	35,210	751,406	67
68	Related Party Allocations (Pages 12H & 12I)		49,774	359		1,167	808	42,274	68
69	Financial Statement Depreciation			72,386			(72,386)		69
70	TOTAL (lines 4 thru 69)		$ 3,206,878	$ 117,317		$ 154,516	$ 37,199	$ 1,826,380	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,206,878	$ 117,317		$ 154,516	$ 37,199	$ 1,826,380	1
2	Pyro Chem Fire System	2007	2,845		20	285	285	1,091	2
3	Cable Jacks	2007	9,840		20	984	984	3,608	3
4	Wiring - 75 Rooms	2007	8,502		20	850	850	3,401	4
5	2 Security Cameras	2007	3,036		20	304	304	1,113	5
6	Roofing	2007	3,200		20	320	320	1,173	6
7	Wallcovering/Carpeting/Cove Base (Building Renovation)	2007	70,433		20	7,043	7,043	21,717	7
8	Replace All Leaking Victaulic Seals On Elevators	2008	5,500		20	275	275	688	8
9	Brickwork	2008	18,800		20	1,880	1,880	4,700	9
10	New Concrete Slabs	2008	3,500		20	350	350	933	10
11	120 Gallon Storage Tank	2008	4,483		20	448	448	1,083	11
12	Wallcovering/Cove Base/Handrails/Molding	2008	156,613		20	15,661	15,661	32,628	12
13	Remote Annunciator	2009	4,575		20	457	457	801	13
14	Monitoring System	2009	4,596		20	460	460	498	14
15	4Th Flr Call System	2009	7,663		20	1,095	1,095	1,642	15
16	Elevator Valve	2010	3,300		20	41	41	41	16
17	Concrete Parking And Sidewalk	2010	7,500		20	375	375	375	17
18	New Generator	2010	81,500		20	2,717	2,717	2,717	18
19	Nurses Call System	2010	15,327		20	3,065	3,065	3,065	19
20	Steinhardt Builders Roof Insulation	2010	5,376		20	90	90	90	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)		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	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)		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,623,466	$ 117,317		$ 191,216	$ 73,899	$ 1,907,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	156 Beds	1973	1,595,648	44,572	30	79,782	35,210	751,406	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,595,648	$ 44,572		$ 79,782	$ 35,210	$ 751,406	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Mazel Management	1985	17,523		30	584	584	14,749	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2008	2,375	182	20	238	56	693	9
10	Allocated From Managcare	1997	2,043		20			2,043	10
11	Allocated From Managcare	1993	160		20	8	8	141	11
12	Allocated From Managcare	1988	250	8	20		(8)	250	12
13	Allocated From Managcare	1986	18,950		20			18,949	13
14									14
15	Allocated From Mazel Management	2007	1,031	26	20	52	26	183	15
16	Allocated From Mazel Management	2006	553	14	20	28	14	124	16
17	Allocated From Mazel Management	2005	413	37	20	41	4	226	17
18	Allocated From Mazel Management	2001	368	9	20	18	9	175	18
19	Allocated From Mazel Management	2000	186	5	20	9	4	95	19
20	Allocated From Mazel Management	1998	656	21	20	33	12	417	20
21	Allocated From Mazel Management	1997	611	16	20	31	15	408	21
22	Allocated From Mazel Management	1996	417	5	20	21	16	304	22
23	Allocated From Mazel Management	1995	94	2	20	5	3	73	23
24	Allocated From Mazel Management	1994	372	7	20	19	12	288	24
25	Allocated From Mazel Management	1993	220	6	20	11	5	192	25
26	Allocated From Mazel Management	1991	165	5	20	8	3	153	26
27	Allocated From Mazel Management	1990	256	5	20	4	(1)	251	27
28	Allocated From Mazel Management	1989	160	4	20	5	1	142	28
29	Allocated From Mazel Management	1987	364	7	20		(7)	364	29
30	Allocated From Mazel Management	1986	1,469		20			1,469	30
31	Allocated From Mazel Management	1985	102		20			102	31
32									32
33	Allocated From Intercare	2001	1,036		20	52	52	483	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 49,774	$ 359		$ 1,167	$ 808	$ 42,274	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 365,920	$ 3,217	$ 16,033	$ 12,816	10	$ 284,699	71
72	Current Year Purchases	12,875	21,818	742	(21,076)	10	742	72
73	Fully Depreciated Assets	715,497				10	715,497	73
74								74
75	TOTALS	$ 1,094,291	$ 25,035	$ 16,775	$ (8,260)		$ 1,000,937	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 Managcare	2009	$ 19,381	$ 2,618	$ 2,580	$ (38)	5	$ 9,667	76
77										77
78										78
79										79
80	TOTALS			$ 19,381	$ 2,618	$ 2,580	$ (38)		$ 9,667	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)	$	4,906,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	144,970	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	210,571	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	65,601	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,918,348	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 14 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,003	$		$ 325,003	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			169,910			169,910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			333,226			333,226	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 prescrpts				142,467		142,467	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					750	113,602		114,352	13
14	TOTAL			$		$ 828,889	$ 256,069		$ 1,084,958	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

STATE OF ILLINOIS

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,886	$ 108,170	1
2	Cash-Patient Deposits	2,704	2,704	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,097,751	1,097,751	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,887	99,564	6
7	Other Prepaid Expenses	15,452	15,452	7
8	Accounts Receivable (owners or related parties)	37,868	37,868	8
9	Other(specify): See Attached Schedule	750,296	792,565	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,987,844	$ 2,154,074	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,991	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	136,176	1,583,199	15
16	Equipment, at Historical Cost	142,192	1,364,893	16
17	Accumulated Depreciation (book methods)	(184,104)	(2,357,763)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	941	1,003,296	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 95,205	$ 3,463,264	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,083,049	$ 5,617,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 957,866	$ 973,960	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	800,000	800,000	29
30	Accrued Salaries Payable	131,882	131,882	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,781	48,781	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,191	32
33	Accrued Interest Payable	992	992	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,069,466	1,069,466	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,008,987	$ 3,142,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,107,416	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,107,416	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,008,987	$ 8,249,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (925,938)	$ (2,632,350)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,083,049	$ 5,617,338	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (348,206)	1
2	Restatements (describe):		2
3	**Reversal of 2008-2009 Depreciation Entry**	95	3
4	**Rounding**	6	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (348,105)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(577,833)	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)**	$ (577,833)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (925,938)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,929,580	1
2	Discounts and Allowances for all Levels	(844,980)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,084,600	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,270,533	6
7	Oxygen	253	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,270,786	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	134,763	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,397	19
20	Radiology and X-Ray	2,110	20
21	Other Medical Services	25,634	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,904	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,901	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,901	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,333	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,333	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,551,524	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,311,036	31
32	Health Care	3,379,287	32
33	General Administration	2,367,899	33
	B. Capital Expense		
34	Ownership	739,796	34
	C. Ancillary Expense		
35	Special Cost Centers	1,245,929	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,129,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	(577,833)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (577,833)	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 Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,768	1,881	$ 70,780	$ 37.63	1
2	Assistant Director of Nursing	1,584	1,640	52,446	31.98	2
3	Registered Nurses	14,473	15,428	453,945	29.42	3
4	Licensed Practical Nurses	41,039	43,021	1,022,365	23.76	4
5	CNAs & Orderlies	93,780	101,257	1,057,072	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,219	8,135	145,937	17.94	8
9	Activity Director	1,872	2,072	29,080	14.03	9
10	Activity Assistants	6,985	7,552	66,646	8.82	10
11	Social Service Workers	9,143	10,035	170,920	17.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,847	20,448	220,318	10.77	15
16	Dishwashers					16
17	Maintenance Workers	8,514	9,304	97,304	10.46	17
18	Housekeepers	23,751	26,066	258,392	9.91	18
19	Laundry	7,293	8,210	86,375	10.52	19
20	Administrator	2,608	2,608	200,181	76.76	20
21	Assistant Administrator	1,864	2,000	76,058	38.03	21
22	Other Administrative	227	227	15,000	66.08	22
23	Office Manager					23
24	Clerical	3,251	3,391	42,612	12.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,911	4,376	56,807	12.98	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,060	3,196	128,864	40.32	33
34	TOTAL (lines 1 - 33)	251,189	270,847	$ 4,251,102 *	$ 15.70	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	466	$ 20,037	01-03	35
36	Medical Director	Monthly	52,900	09-03	36
37	Medical Records Consultant	96	4,416	10-03	37
38	Nurse Consultant	Monthly	3,375	10-03	38
39	Pharmacist Consultant	Monthly	7,488	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	315	10a-03	42
43	Speech Therapy Consultant	18	995	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	61	3,416	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	648	$ 92,942		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 360	10-03	50
51	Licensed Practical Nurses	24	777	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	32	$ 1,137		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Moshe Davis (1/1-12/31)	Administrator	0.56%	$ 192,801
Yosef Davis	Admin. Consult	69.38%	15,000
Yisroel Davis	Asst. Admin.	0.56%	76,058
Martin Olsen (6/4-6/21)	Administrator	0.00%	7,380
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 291,239

B. Administrative - Other

Description	Amount
Management Fees- Intercare	$ 230,544
TOTAL (agree to Schedule V, line 17, col. 3)	$ 230,544
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Managcare, Inc	Bookkeeping	$ 190,944
E-Health Data Solutions	Computer Services	5,518
RH Positive	Computer Services	642
American Data	Computer Services	4,078
Kipp Computer Solutions	Computer Services	2,400
Kronos	Computer Services	380
Property Valuation Services	Appraisal	3,000
Cimpar Consulting	Strategic Consulting	1,400
Personnel Planners	Unemployment Tax Consult	2,304
Honkamp Krueger	Unemployment Tax Consult	3,046
See Attached	Legal	196,800
See Supplemetal Schedule		20,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 430,762

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,980
Unemployment Compensation Insurance	41,906
FICA Taxes	320,704
Employee Health Insurance	223,035
Employee Meals	44,366
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,376
Dental Insurance	10
Other Employee Benefits	11,101
Holiday Expense	9,239
Pension Expense	38,543
Disability Insurance	3,678
TOTAL (agree to Schedule V, line 22, col.8)	$ 742,938

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	275
Health Care Worker Background Check	
(Indicate # of checks performed)	2,280
Patient Background Checks	
Licenses & Permits	2,343
Dues & Subscriptions	11,734
Advertising & Promotions	28,652
See Supplemental Schedule	654
Less: Public Relations Expense	( )
Non-allowable advertising	(28,652)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,281

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,798
Allocated From Managcare	312
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,110

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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 & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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. **IL Assoc. of HC $1,872 ; ICLTC $13,338**

(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. $ **32,880** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **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. $ **85,410**
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. $ **44,366** Has any meal income been offset against related costs? **N/A** 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% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, 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.