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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0029660

Facility Name: Mayfield Care Center

Address: 5905 W. Washington Blvd. (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: 01/01/85

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 01/01/11 to 12/31/11 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: 01/01/11 Ending: 12/31/11

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	22,891		4,039	26,930	8
9	SNF/PED					9
10	ICF	17,929	346		18,275	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,820	346	4,039	45,205	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.39%

D. How many bed-hold days during this year were paid by the Department?
12 (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 104 and days of care provided 3,439

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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: 01/01/11 Ending: 12/31/11

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	279,110	62,243	13,115	354,468		354,468		354,468			1
2	Food Purchase		260,592		260,592	(48,089)	212,503	(1,788)	210,715			2
3	Housekeeping	277,909	83,803		361,712		361,712	608	362,320			3
4	Laundry	88,400	19,221		107,621		107,621		107,621			4
5	Heat and Other Utilities			150,279	150,279		150,279	1,983	152,262			5
6	Maintenance	108,948	24,216	35,444	168,608		168,608	14,192	182,800			6
7	Other (specify):*											7
8	TOTAL General Services	754,367	450,075	198,838	1,403,280	(48,089)	1,355,191	14,995	1,370,186			8
	B. Health Care and Programs											
9	Medical Director			45,600	45,600		45,600		45,600			9
10	Nursing and Medical Records	2,721,548	158,932	15,278	2,895,758		2,895,758	(17)	2,895,741			10
10a	Therapy	152,381		830	153,211		153,211		153,211			10a
11	Activities	105,058	18,768	2,819	126,645		126,645		126,645			11
12	Social Services	141,156		644	141,800		141,800		141,800			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,120,143	177,700	65,171	3,363,014		3,363,014	(17)	3,362,997			16
	C. General Administration											
17	Administrative	100,841		230,544	331,385		331,385	(142,727)	188,658			17
18	Directors Fees											18
19	Professional Services			311,697	311,697		311,697	(257,019)	54,678			19
20	Dues, Fees, Subscriptions & Promotions			138,998	138,998		138,998	(98,308)	40,690			20
21	Clerical & General Office Expenses	133,387	53,981	258,211	445,579		445,579	(120,641)	324,938			21
22	Employee Benefits & Payroll Taxes			717,331	717,331	48,089	765,420		765,420			22
23	Inservice Training & Education			925	925		925		925			23
24	Travel and Seminar			1,166	1,166		1,166	(129)	1,037			24
25	Other Admin. Staff Transportation			3,116	3,116		3,116	(306)	2,810			25
26	Insurance-Prop.Liab.Malpractice			958	958		958	125,772	126,730			26
27	Other (specify):*							48,991	48,991			27
28	TOTAL General Administration	234,228	53,981	1,662,946	1,951,155	48,089	1,999,244	(444,367)	1,554,876			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,108,738	681,756	1,926,955	6,717,449		6,717,449	(429,389)	6,288,060			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: 01/01/11 Ending: 12/31/11

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			44,661	44,661		44,661	167,908	212,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,079	57,079		57,079	288,570	345,649			32
33	Real Estate Taxes			(2,305)	(2,305)		(2,305)	152,944	150,639			33
34	Rent-Facility & Grounds			722,000	722,000		722,000	(722,000)	(0)			34
35	Rent-Equipment & Vehicles			8,328	8,328		8,328	(7,889)	439			35
36	Other (specify):*							25,120	25,120			36
37	**TOTAL Ownership**			829,763	829,763		829,763	(95,347)	734,416			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		226,266	702,711	928,977		928,977		928,977			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,539	258,539		258,539		258,539			42
43	Other (specify):*	123,633		27,686	151,319		151,319	(151,319)				43
44	**TOTAL Special Cost Centers**	123,633	226,266	988,936	1,338,835		1,338,835	(151,319)	1,187,516			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,232,371	908,022	3,745,654	8,886,047		8,886,047	(676,055)	8,209,992			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: 01/01/11 Ending: 12/31/11

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	(4,535)	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	35,058	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(3,330)	21		18
19	Entertainment	(357)	24		19
20	Contributions	(56,860)	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	(224,107)	21		24
25	Fund Raising, Advertising and Promotional	(37,351)	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	(193,609)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (485,111)		$	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)	(190,944)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (190,944)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (676,055)		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: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,768)	02	1
2	Marketing Salary	(123,633)	43	2
3	Marketing Consultant	(27,686)	43	3
4	Annual Fees	(875)	20	4
5	Bank Charges	(1,984)	21	5
6	Theft & Loss	(44)	21	6
7	Building Company Annual Report	(255)	20	7
8	Building Company Accounting	(10,500)	19	8
9	Building Company Amortization	(1,598)	31	9
10	Additional R&M	10,224	06	10
11	Non-Allowable Auto Lease	(8,328)	35	11
12	Jury Duty Income- DON	(17)	10	12
13	Election Income	(275)	21	13
14	Prior Period Professional Fee	(941)	19	14
15	Non-Allowable Accounting Fee	(5,000)	19	15
16	Non-Allowable Travel	(345)	25	16
17	COPE Dues	(3,762)	20	17
18	Non-Allowable Legal	(16,822)	19	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**	(193,609)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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:** 01/01/11 **Ending:** 12/31/11

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	(1,788)											(1,788)	2
3	Housekeeping			583		25							608	3
4	Laundry													4
5	Heat and Other Utilities			1,090		893							1,983	5
6	Maintenance	5,689		7,907		596							14,192	6
7	Other (specify):*													7
8	**TOTAL General Services**	3,901		9,580		1,514							14,995	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			58,398	(201,550)	425							(142,727)	17
18	Directors Fees													18
19	Professional Services	(33,263)	10,500	(234,318)		62							(257,019)	19
20	Fees, Subscriptions & Promotions	(99,103)	255	522	18								(98,308)	20
21	Clerical & General Office Expenses	(229,740)		109,062	37								(120,641)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(357)		228									(129)	24
25	Other Admin. Staff Transportation	(345)		39									(306)	25
26	Insurance-Prop.Liab.Malpractice		125,071	529		172							125,772	26
27	Other (specify):*			46,808	2,183								48,991	27
28	**TOTAL General Administration**	(362,808)	135,826	(18,732)	(199,312)	659							(444,367)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(358,924)	135,826	(9,152)	(199,312)	2,173							(429,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	35,058	129,908	2,714		228							167,908	30
31	Amortization of Pre-Op. & Org.	(1,598)	1,598											31
32	Interest		286,593	187		1,790							288,570	32
33	Real Estate Taxes		150,745			2,199							152,944	33
34	Rent-Facility & Grounds		(722,000)	8,746		(8,746)							(722,000)	34
35	Rent-Equipment & Vehicles	(8,328)		439									(7,889)	35
36	Other (specify):*		25,120										25,120	36
37	**TOTAL Ownership**	25,132	(128,036)	12,086		(4,529)							(95,347)	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):*	(151,319)											(151,319)	43
44	**TOTAL Special Cost Centers**	(151,319)											(151,319)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(485,111)	7,790	2,934	(199,312)	(2,356)							(676,055)	45

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 722,000	Mayfield Building Limited	100.00%	$	$ (722,000)	1
2	V	32	Interest Income	220	Mayfield Building Limited	100.00%		(220)	2
3	V	32	Interest Expense		Mayfield Building Limited	100.00%	286,813	286,813	3
4	V	33	Real Estate Taxes		Mayfield Building Limited	100.00%	150,745	150,745	4
5	V	26	Insurance Expense		Mayfield Building Limited	100.00%	125,071	125,071	5
6	V	20	Annual Report Fees		Mayfield Building Limited	100.00%	255	255	6
7	V	30	Depreciation Expense		Mayfield Building Limited	100.00%	129,908	129,908	7
8	V	36	Mortgage Insurance		Mayfield Building Limited	100.00%	25,120	25,120	8
9	V	19	Accounting Fees		Mayfield Building Limited	100.00%	10,500	10,500	9
10	V	31	Amortization		Mayfield Building Limited	100.00%	1,598	1,598	10
11	V								11
12	V								12
13	V								13
14	Total			$ 722,220			$ 730,010	$ * 7,790	14

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 583	$ 583	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,090	1,090	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	7,907	7,907	17
18	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	58,398	58,398	18
19	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	301	301	19
20	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	522	522	20
21	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	109,062	109,062	21
22	V	24	SEMINARS		MANAGCARE, INC.	100.00%	228	228	22
23	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	39	39	23
24	V	26	INSURANCE		MANAGCARE, INC.	100.00%	529	529	24
25	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	46,808	46,808	25
26	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	2,714	2,714	26
27	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	187	187	27
28	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	8,746	8,746	28
29	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	439	439	29
30	V								30
31	V	19	BOOKKEEPING/COMPUTER SERV	234,619	MANAGCARE, INC.	100.00%		(234,619)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 234,619			$ 237,553	$ * 2,934	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: 01/01/11 Ending: 12/31/11

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%	$ 28,994	$ 28,994	15
16	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	18	18	16
17	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	37	37	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	2,183	2,183	18
19	V								19
20	V	17	MANAGEMENT FEES	230,544	INTERCARE, LTD. C/O MANAGCARE	100.00%		(230,544)	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			$ 230,544			$ 31,232	$ * (199,312)	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: 01/01/11 Ending: 12/31/11

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	$	3553 WEST PETERSON AVE BLDG. PTR.	100.00%	$ 25	$ 25	15
16	V	5	UTILITIES		3553 WEST PETERSON AVE BLDG. PTR.		893	893	16
17	V	6	REPAIRS & MAINT.		3553 WEST PETERSON AVE BLDG. PTR.		596	596	17
18	V	17	ADMIN.-M. WOLF		3553 WEST PETERSON AVE BLDG. PTR.		425	425	18
19	V	19	PROFESSIONAL FEES		3553 WEST PETERSON AVE BLDG. PTR.		62	62	19
20	V	26	INSURANCE		3553 WEST PETERSON AVE BLDG. PTR.		172	172	20
21	V	30	DEPRECIATION		3553 WEST PETERSON AVE BLDG. PTR.		228	228	21
22	V	32	INTEREST EXPENSE		3553 WEST PETERSON AVE BLDG. PTR.		1,790	1,790	22
23	V	33	REAL ESTATE TAXES		3553 WEST PETERSON AVE BLDG. PTR.		2,199	2,199	23
24	V								24
25	V	34	RENT	8,746	3553 WEST PETERSON AVE BLDG. PTR.			(8,746)	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			$ 8,746			$ 6,390	$ * (2,356)	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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	AHUVA WEINREB	0.555%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	MAYFIELD BUILDING LIMITED		BUILDING CO.	1
2	BRACHA WOLF	1.570%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	MANAGCARE, INC.		Management Co	2
3	DAVIS FAMILY TRUST	10.000%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	INTERCARE, LTD. C/O MANAG		Management Co	3
4	EDIE DAVIS	0.055%			3553 WEST PETERSON AVE BLI		Building Co	4
5	ELIYAHU DAVIS	0.555%						5
6	MOSHE DAVIS	0.555%						6
7	NESANEL DAVIS	0.555%						7
8	RENITA O'CONNELL	1.570%						8
9	SHOSHANA BRAUN	0.555%						9
10	YEHOSHUA DAVIS	0.555%						10
11	YISROEL DAVIS	0.555%						11
12	YOSEF DAVIS	69.375%						12
13	YOSEF DAVIS DELTA TRUST 7/18/01	13.540%						13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	4.35	14.50%	Sal./Al.Sal	$ 43,994	17-1, 17-7	1
2	Moshe Davis	Shareholder	Mgmt/Admin	0.56%	See Attached	7.5	17.05%	Sal./Al.Sal	39,001	17-1, 17-7	2
3	Moshe Wolf	Relative	Administrative	0.00%	See Attached	6.82	14.21%	Alloc.Sal/Fees	16,127	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	7.16	17.05%	Alloc. Salary	18,383	17-7	4
5											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	$ 117,505		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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	265,143	4	$ 3,420	$	45,205	$ 583	1
2	5	UTILITIES	PATIENT DAYS	265,143	4	6,395		45,205	1,090	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	265,143	4	46,378		45,205	7,907	3
4	17	ADMINISTRATIVE	PATIENT DAYS	265,143	4	342,522	342,522	45,205	58,398	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	265,143	4	1,765		45,205	301	5
6	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	265,143	4	3,059		45,205	522	6
7	21	CLERICAL AND GENERAL	PATIENT DAYS	265,143	4	639,686	395,180	45,205	109,062	7
8	24	SEMINARS	PATIENT DAYS	265,143	4	1,339		45,205	228	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	265,143	4	229		45,205	39	9
10	26	INSURANCE	PATIENT DAYS	265,143	4	3,101		45,205	529	10
11	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	265,143	4	274,547		45,205	46,808	11
12	30	DEPRECIATION	PATIENT DAYS	265,143	4	15,921		45,205	2,714	12
13	32	INTEREST EXPENSE	PATIENT DAYS	265,143	4	1,096		45,205	187	13
14	34	RENT - BUILDING (RELATED)	PATIENT DAYS	265,143	4	51,300		45,205	8,746	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	265,143	4	2,577		45,205	439	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,393,335	$ 737,703		$ 237,553	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 28,994	1
2	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	75		4	18	2
3	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	155		4	37	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	9,037		4	2,183	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					$ 129,267	$ 120,000		$ 31,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 3553 WEST PETERSON AVE BLDG. PTR.
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	265,143	4	$ 147	$	45,205	$ 25	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	265,143	4	5,239		45,205	893	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	265,143	4	3,498		45,205	596	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	265,143	4	2,492		45,205	425	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	265,143	4	363		45,205	62	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	265,143	4	1,007		45,205	172	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	265,143	4	1,338		45,205	228	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	265,143	4	10,498		45,205	1,790	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	265,143	4	12,899		45,205	2,199	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					$ 37,481	$		$ 6,390	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$ 5,038,924			$ 286,813	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				1,000,000			40,924	6
7	Al From 3553 West Peterson Ave Bldg.		X								1,790	7
8	See Supplemental Schedule										187	8
9	TOTAL Facility Related						$	$ 6,038,924			$ 329,714	9
	B. Non-Facility Related*											
10	Miscellaneous Interest Expense		X								16,155	10
11	Interest Income-Bldg Co.		X								(220)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 15,935	14
15	TOTALS (line 9+line14)						$	$ 6,038,924			$ 345,649	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 25,120 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: 01/01/11 Ending: 12/31/11

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				$	$			$ 187	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										187	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:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 117,191	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.)		$ 132,529	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,338	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 135,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 150,638	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	55,314	8
	2007	54,724	9
	2008	55,272	10
	2009	124,892	11
	2010	130,330	12

2011 Accrual=$130,330 X 1.04 = $135,300 (Rounded)

Allocated From 3553 West Peterson Ave Bldg. Ptr. =$2,199

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(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	$ 1,025.15	$ 1,025.15
2.	16-08-419-003-0000	Long Term Care Property	$ 29,213.32	$ 29,213.32
3.	16-08-419-004-0000	Long Term Care Property	$ 43,570.07	$ 43,570.07
4.	16-08-419-005-0000	Long Term Care Property	$ 30,086.20	$ 30,086.20
5.	16-08-419-006-0000	Long Term Care Property	$ 20,983.13	$ 20,983.13
6.	16-08-419-007-0000	Long Term Care Property	$ 5,451.71	$ 5,451.71
7.	See Attached	Al. From Managcare/3553 West Peters	$ 53,964.18	$ 2,109.34
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 184,293.76	$ 132,438.92

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156			1973	$ 1,595,648	$ 44,604	30	$ 79,782	$ 35,178	$ 831,188	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	9,629	11
12	Various			1988	38,957		20	1,257	1,257	29,640	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	1,067	1,067	36,361	14
15	Various			1991	34,073		20	1,273	1,273	34,073	15
16	Various			1992	1,200		20	60	60	1,190	16
17	Various			1993	6,071		20	304	304	5,579	17
18	Various			1994	24,281		20	1,214	1,214	20,915	18
19	Various			1995	1,467		20	73	73	1,204	19
20	Various			1996	64,140		20	3,207	3,207	49,843	20
21	Various			1997	15,923		20	796	796	11,589	21
22	Various			1998	966,314		20	48,316	48,316	636,242	22
23	Various			1999	137,374		20	6,869	6,869	86,864	23
24	Various			2000	43,701		20	1,358	1,358	32,363	24
25	Various			2001	9,572		20	361	361	7,272	25
26	Various			2002	14,269		20	1,427	1,427	13,781	26
27	Various			2003	3,119		20	107	107	1,893	27
28	Various			2004	32,093		20	1,687	1,687	17,928	28
29	Various			2005	14,586		20	1,491	1,491	10,099	29
30	Various			2006	8,163		20	827	827	4,578	30
31	Various			2007	97,856		20	9,786	9,786	41,888	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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)								67
68	Related Party Allocations (Pages 12H & 12I)		50,796	365		1,219	854	43,665	68
69	Financial Statement Depreciation			86,685			(86,685)		69
70	TOTAL (lines 4 thru 69)		$ 3,305,755	$ 131,654		$ 162,871	$ 31,217	$ 2,021,526	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,305,755	$ 131,654		$ 162,871	$ 31,217	$ 2,021,526	1
2	Replace All Leaking Victaulic Seals On Elevators	2008	5,500		20	275	275	963	2
3	Brickwork	2008	18,800		20	1,880	1,880	6,580	3
4	New Concrete Slabs	2008	3,500		20	350	350	1,283	4
5	120 Gallon Storage Tank	2008	4,483		20	448	448	1,532	5
6	Wallcovering/Cove Base/Handrails/Molding	2008	156,613		20	15,661	15,661	48,289	6
7	Remote Annunciator	2009	4,575		20	457	457	1,258	7
8	Monitoring System	2009	4,596		20	460	460	958	8
9	4Th Flr Call System	2009	7,663		20	1,095	1,095	2,737	9
10	Elevator Valve	2010	3,300		20	165	165	206	10
11	Concrete Parking And Sidewalk	2010	7,500		20	750	750	1,000	11
12	New Generator	2010	81,500		20	4,075	4,075	4,754	12
13	Nurses Call System	2010	15,327		20	3,065	3,065	6,131	13
14	Steinhardt Builders Roof Insulation	2010	5,376		20	538	538	627	14
15	Wall-Mounted Sign	2011	8,311		20	277	277	277	15
16	East And West Passenger Elevator	2011	78,711		20	656	656	656	16
17	Copper Piping	2011	5,200		20	303	303	303	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)		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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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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)		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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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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)		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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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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)		$ 3,716,711	$ 131,654		$ 193,327	$ 61,673	$ 2,099,080	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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
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23									23
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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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company 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
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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)		$	$		$	$	$	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1985	17,589		30	586	586	15,391	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Managcare	2008	2,384	130	20	238	108	934	9
10	Allocated From Managcare	1997	2,051		20			2,051	10
11	Allocated From Managcare	1993	161		20	8	8	149	11
12	Allocated From Managcare	1988	251	8	20		(8)	251	12
13	Allocated From Managcare	1986	19,022		20			19,022	13
14	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2011	806	57	20	53	(4)	53	14
15	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2007	1,035	27	20	52	25	235	15
16	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2006	555	14	20	28	14	153	16
17	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2005	415	37	20	42	5	269	17
18	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2001	369	9	20	18	9	194	18
19	Allocated From 3553 West Peterson Ave Bldg. Ptr.	2000	187	5	20	9	4	105	19
20	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1998	658	21	20	33	12	451	20
21	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1997	614	16	20	31	15	440	21
22	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1996	418	5	20	21	16	326	22
23	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1995	95	2	20	5	3	78	23
24	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1994	373	7	20	19	12	307	24
25	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1993	221	6	20	11	5	203	25
26	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1991	165	5	20	7	2	161	26
27	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1990	257	5	20		(5)	252	27
28	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1989	161	4	20	5	1	147	28
29	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1987	365	7	20		(7)	365	29
30	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1986	1,474		20			1,474	30
31	Allocated From 3553 West Peterson Ave Bldg. Ptr.	1985	103		20			103	31
32									32
33	Allocated From Intercare	2001	1,067		20	53	53	551	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party 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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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)		$ 50,796	$ 365		$ 1,219	$ 854	$ 43,665	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 350,548	$ 20,936	$ 14,377	$ (6,559)	10	$ 272,360	71
72	Current Year Purchases	15,322	23,651	1,658	(21,993)	10	1,658	72
73	Fully Depreciated Assets	744,040		60	60	10	743,945	73
74								74
75	TOTALS	$ 1,109,909	$ 44,587	$ 16,094	$ (28,493)		$ 1,017,962	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Managcare	2010	$ 19,454	$ 1,269	$ 3,147	$ 1,878	5	$ 12,851	76
77										77
78										78
79										79
80	TOTALS			$ 19,454	$ 1,269	$ 3,147	$ 1,878		$ 12,851	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)	$	5,015,065	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	177,510	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	212,568	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	35,058	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,129,893	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: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 439 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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	$		$ 277,459	$		$ 277,459	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			163,482			163,482	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			255,538			255,538	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				124,324		124,324	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					6,232	101,942		108,174	13
14	TOTAL			$		$ 702,711	$ 226,266		$ 928,977	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:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/11 **(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	$ 500	$ 17,355	1
2	Cash-Patient Deposits	3,121	3,121	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,620,461	2,620,461	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,864	119,532	6
7	Other Prepaid Expenses	21,133	21,133	7
8	Accounts Receivable (owners or related parties)	37,768	37,768	8
9	Other(specify): See Attached Schedule	750,379	1,070,260	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,503,226	$ 3,889,630	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	144,487	1,671,840	15
16	Equipment, at Historical Cost	166,561	1,392,843	16
17	Accumulated Depreciation (book methods)	(228,765)	(2,532,332)	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	625	806,532	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 82,908	$ 3,208,522	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,586,134	$ 7,098,152	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,248,638	$ 1,300,635	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	161,804	161,804	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,208	48,208	31
32	Accrued Real Estate Taxes(Sch.IX-B)		135,300	32
33	Accrued Interest Payable	3,069	3,069	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,107,809	2,107,809	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,569,528	$ 4,756,825	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,038,924	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)**	$	$ 5,038,924	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,569,528	$ 9,795,749	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (983,394)	$ (2,697,597)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,586,134	$ 7,098,152	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (925,938)	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (925,935)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(57,459)	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)**	$ (57,459)	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)**	$ (983,394)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 8,328,804	1
2	Discounts and Allowances for all Levels	(723,324)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,605,480	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,077,446	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,077,446	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	112,781	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,390	19
20	Radiology and X-Ray	3,887	20
21	Other Medical Services	19,544	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 143,602	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,060	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,060	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,828,588	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,403,280	31
32	Health Care	3,363,014	32
33	General Administration	1,951,155	33
	B. Capital Expense		
34	Ownership	829,763	34
	C. Ancillary Expense		
35	Special Cost Centers	1,080,296	35
36	Provider Participation Fee	258,539	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,886,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	(57,459)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (57,459)	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: 01/01/11 Ending: 12/31/11

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	1,936	2,160	$ 90,094	$ 41.71	1
2	Assistant Director of Nursing	2,107	2,162	74,614	34.51	2
3	Registered Nurses	13,832	14,362	436,870	30.42	3
4	Licensed Practical Nurses	40,972	43,357	1,040,656	24.00	4
5	CNAs & Orderlies	89,998	98,714	1,019,626	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,010	10,044	152,381	15.17	8
9	Activity Director	1,955	2,091	29,387	14.05	9
10	Activity Assistants	7,573	8,228	75,671	9.20	10
11	Social Service Workers	8,002	8,660	141,156	16.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,689	24,091	279,110	11.59	15
16	Dishwashers					16
17	Maintenance Workers	9,321	10,089	108,948	10.80	17
18	Housekeepers	26,602	29,047	277,909	9.57	18
19	Laundry	7,380	8,262	88,400	10.70	19
20	Administrator	1,912	2,000	77,957	38.98	20
21	Assistant Administrator					21
22	Other Administrative	346	346	22,884	66.14	22
23	Office Manager					23
24	Clerical	6,114	6,706	133,387	19.89	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	3,924	4,368	59,688	13.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,890	3,050	123,633	40.54	33
34	TOTAL (lines 1 - 33)	256,563	277,737	$ 4,232,371 *	$ 15.24	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	286	$ 13,115	01-03	35
36	Medical Director	Monthly	45,600	09-03	36
37	Medical Records Consultant	Monthly	1,880	10-03	37
38	Nurse Consultant	12	5,910	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	15	830	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,819	11-03	44
45	Social Service Consultant	12	644	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	375	$ 78,286		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		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: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shai Berdugo	Administrator	0.00%	$ 77,956
Yosef Davis	Admin Consult	69.38%	15,000
Moshe Davis	Operations Dir.	0.56%	7,884
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,840

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	$ 234,000
Managcare, Inc	Computer Services	619
E-Health Data Solutions	Computer Services	5,518
American Data	Computer Services	4,332
Adar	Computer Services	1,654
Cimpar Consulting	Strategic Consulting	4,060
Personnel Planners	Unemployment Consult	4,042
Honkamp Krueger	Unemployment Consult	3,188
Moshe Calamaro	Architect (Adj Pg 5a)	941
Frost, Ruttenberg & Rothblatt	Accounting	20,250
Legal	See Attached	33,093
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 311,697

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,776
Unemployment Compensation Insurance	56,208
FICA Taxes	319,439
Employee Health Insurance	195,736
Employee Meals	48,089
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	5,008
Other Employee Benefits	4,445
Holiday Expense	13,624
Pension Expense	39,275
Disability Insurance	3,820
TOTAL (agree to Schedule V, line 22, col.8)	$ 765,420

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	$
Advertising: Employee Recruitment	14,231
Health Care Worker Background Check	2,430
(Indicate # of checks performed 78)	
Patient Background Checks 140	1,565
Advertising & Promotions	37,350
License & Permits	2,996
Dues & Subscriptions	18,928
See Supplemental Schedule	540
Less: Public Relations Expense	( )
Non-allowable advertising	(37,350)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,690

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	809
Allocated From Managcare	228
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,037

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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 Council on LTC $15,116; IL NH Assoc $100**

(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. $ **39,227** 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. $ **258,539**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **48,089** 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.