FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH 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: 363336671001

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: slavenda@frrcpas.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	57,096	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	57,096	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	24,163		6,332	30,495	8
9	SNF/PED					9
10	ICF	18,986	667		19,653	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,149	667	6,332	50,148	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.83%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 5,576

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: 12/31/2012 Fiscal Year: 12/31/2012

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

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	304,594	61,394	11,304	377,292		377,292	36	377,328			1
2	Food Purchase		315,027		315,027	(53,820)	261,207	(1,581)	259,626			2
3	Housekeeping	199,588	48,443	50,062	298,093		298,093	1,972	300,065			3
4	Laundry	85,873	12,130	35,122	133,125		133,125		133,125			4
5	Heat and Other Utilities			126,665	126,665		126,665	(3,300)	123,365			5
6	Maintenance	119,581	27,641	71,014	218,236		218,236	19,972	238,208			6
7	Other (specify):*											7
8	TOTAL General Services	709,636	464,635	294,167	1,468,438	(53,820)	1,414,618	17,099	1,431,717			8
	B. Health Care and Programs											
9	Medical Director			32,525	32,525		32,525	7,398	39,923			9
10	Nursing and Medical Records	2,871,829	178,461	36,534	3,086,824		3,086,824	(1,524)	3,085,300			10
10a	Therapy	154,906		14,543	169,449		169,449		169,449			10a
11	Activities	154,308	24,736	5,096	184,140		184,140		184,140			11
12	Social Services	176,704			176,704		176,704		176,704			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,357,747	203,197	88,698	3,649,642		3,649,642	5,874	3,655,516			16
	C. General Administration											
17	Administrative	153,635		230,544	384,179		384,179	(93,199)	290,980			17
18	Directors Fees											18
19	Professional Services			367,044	367,044		367,044	(279,301)	87,743			19
20	Dues, Fees, Subscriptions & Promotions			182,805	182,805		182,805	(134,636)	48,169			20
21	Clerical & General Office Expenses	146,070	31,223	661,950	839,243		839,243	(486,077)	353,166			21
22	Employee Benefits & Payroll Taxes			822,552	822,552	53,820	876,372		876,372			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,115	4,115		4,115	(1,233)	2,882			24
25	Other Admin. Staff Transportation			1,613	1,613		1,613	224	1,837			25
26	Insurance-Prop.Liab.Malpractice			52,033	52,033		52,033	123,083	175,116			26
27	Other (specify):*							49,452	49,452			27
28	TOTAL General Administration	299,705	31,223	2,322,656	2,653,584	53,820	2,707,404	(821,687)	1,885,717			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,367,088	699,055	2,705,521	7,771,664		7,771,664	(798,714)	6,972,950			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: 01/01/12 Ending: 12/31/12

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			26,670	26,670		26,670	200,189	226,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,701	116,701		116,701	415,750	532,451			32
33	Real Estate Taxes			1,021	1,021		1,021	128,804	129,825			33
34	Rent-Facility & Grounds			636,063	636,063		636,063	(636,063)				34
35	Rent-Equipment & Vehicles			8,328	8,328		8,328	(7,892)	436			35
36	Other (specify):*							6,545	6,545			36
37	**TOTAL Ownership**			788,783	788,783		788,783	107,333	896,116			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,329	1,033,993	1,254,322		1,254,322		1,254,322			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			355,832	355,832		355,832	(6)	355,826			42
43	Other (specify):*	115,065		8,167	123,232		123,232	(123,232)				43
44	**TOTAL Special Cost Centers**	115,065	220,329	1,397,992	1,733,386		1,733,386	(123,238)	1,610,148			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,482,153	919,384	4,892,296	10,293,833		10,293,833	(814,619)	9,479,214			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: 01/01/12 Ending: 12/31/12

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 Refer-ence	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	(4,825)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,147	30		9
10	Interest and Other Investment Income	(622)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,284)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	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	(15)	21		18
19	Entertainment				19
20	Contributions	(69,615)	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	(592,217)	21		24
25	Fund Raising, Advertising and Promotional	(60,878)	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	(243,601)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (933,952)		$	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)	119,333		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 119,333		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (814,619)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,539)	02	1
2	Veterans Expenses	(1,059)	10	2
3	Bank Charges	(6,423)	21	3
4	Marketing Salary	(115,065)	43	4
5	Franchise Taxes	(800)	21	5
6	Annual Fees	(75)	20	6
7	Marketing Consultant	(8,167)	43	7
8	COPE Dues	(6,709)	20	8
9	Non-Allowable Accounting Fee	(5,000)	19	9
10	Additional R&M	9,900	06	10
11	Non-Allowable Auto Lease	(8,328)	35	11
12	Non-Allowable Seminars	(1,671)	24	12
13	Non-Allowable Legal	(14,814)	19	13
14	Capitalized R&M	(3,250)	06	14
15	Building Company Annual Report	(100)	20	15
16	Building Company Accounting Fees	(10,500)	19	16
17	Building Company Amortization	(46,269)	31	17
18	Collections Expense	(1,093)	21	18
19	Prior Year Bed Tax	(6)	42	19
20	Perior Period Legal	(13,449)	19	20
21	Prioer Period Office Expense	(5,161)	21	21
22	Miscellaneous Income	(33)	21	22
23	Jury Duty Income	(465)	10	23
24	Polling Place Income	(525)	21	24
25	Non-Allowable Appraisal Fee	(3,000)	19	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**	(243,601)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			36									36	1
2	Food Purchase	(1,581)											(1,581)	2
3	Housekeeping			1,972									1,972	3
4	Laundry													4
5	Heat and Other Utilities	(4,825)		1,525									(3,300)	5
6	Maintenance	6,650		13,322									19,972	6
7	Other (specify):*													7
8	**TOTAL General Services**	244		16,855									17,099	8
	B. Health Care and Programs													
9	Medical Director			7,398									7,398	9
10	Nursing and Medical Records	(1,524)											(1,524)	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**	(1,524)		7,398									5,874	16
	C. General Administration													
17	Administrative			130,731	(223,930)								(93,199)	17
18	Directors Fees													18
19	Professional Services	(46,763)	10,500	(243,173)		135							(279,301)	19
20	Fees, Subscriptions & Promotions	(137,377)	100	2,619	22								(134,636)	20
21	Clerical & General Office Expenses	(607,551)	(3)	121,467	10								(486,077)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,671)		438									(1,233)	24
25	Other Admin. Staff Transportation			224									224	25
26	Insurance-Prop.Liab.Malpractice		122,851	232									123,083	26
27	Other (specify):*			48,948	504								49,452	27
28	**TOTAL General Administration**	(793,362)	133,448	61,486	(223,394)	135							(821,687)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(794,642)	133,448	85,739	(223,394)	135							(798,714)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	39,147	132,666	24,783		3,593							200,189	30
31	Amortization of Pre-Op. & Org.	(46,269)	46,269											31
32	Interest	(622)	411,015	548		4,809							415,750	32
33	Real Estate Taxes		124,767			4,037							128,804	33
34	Rent-Facility & Grounds		(636,063)	15,704		(15,704)							(636,063)	34
35	Rent-Equipment & Vehicles	(8,328)		436									(7,892)	35
36	Other (specify):*		6,545										6,545	36
37	TOTAL Ownership	(16,072)	85,199	41,471		(3,265)							107,333	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	(6)											(6)	42
43	Other (specify):*	(123,232)											(123,232)	43
44	TOTAL Special Cost Centers	(123,238)											(123,238)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(933,952)	218,647	127,210	(223,394)	(3,130)							(814,619)	45

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

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	$ 636,063	Mayfield Building Limited	100.00%	$	$ (636,063)	1
2	V	32	Interest Income	183	Mayfield Building Limited	100.00%		(183)	2
3	V	32	Interest Expense		Mayfield Building Limited	100.00%	411,198	411,198	3
4	V	33	Real Estate Taxes		Mayfield Building Limited	100.00%	124,767	124,767	4
5	V	26	Insurance Expense		Mayfield Building Limited	100.00%	122,851	122,851	5
6	V	20	Annual Report Fees		Mayfield Building Limited	100.00%	100	100	6
7	V	30	Depreciation Expense		Mayfield Building Limited	100.00%	132,666	132,666	7
8	V	36	Mortgage Insurance		Mayfield Building Limited	100.00%	6,545	6,545	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%	46,269	46,269	10
11	V	21	Office Expense	3				(3)	11
12	V								12
13	V								13
14	Total			$ 636,249			$ 854,896	$ * 218,647	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1	DIETARY	$	MANAGCARE, INC.	100.00%	$ 36	$ 36	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,972	1,972	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,525	1,525	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	13,322	13,322	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	7,398	7,398	19
20	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	130,731	130,731	20
21	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%			21
22	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	2,619	2,619	22
23	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	121,467	121,467	23
24	V	24	SEMINARS		MANAGCARE, INC.	100.00%	438	438	24
25	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	224	224	25
26	V	26	INSURANCE		MANAGCARE, INC.	100.00%	232	232	26
27	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	48,948	48,948	27
28	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	24,783	24,783	28
29	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	548	548	29
30	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	15,704	15,704	30
31	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	436	436	31
32	V								32
33	V	19	BOOKKEEPING/COMPUTER SERV	243,173	MANAGCARE, INC.	100.00%		(243,173)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 243,173			$ 370,383	$ * 127,210	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: 01/01/12 Ending: 12/31/12

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%	$ 6,614	$ 6,614	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	22	22	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	10	10	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	504	504	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V	32	INTEREST EXPENSE		INTERCARE, LTD. C/O MANAGCARE	100.00%			21
22	V	35	EQUIPMENT RENTAL		INTERCARE, LTD. C/O MANAGCARE	100.00%			22
23	V								23
24	V	17	MANAGEMENT FEES	230,544	INTERCARE, LTD. C/O MANAGCARE	100.00%		(230,544)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 230,544			$ 7,150	$ * (223,394)	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: 01/01/12 Ending: 12/31/12

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	$	4600 TOUHY, LLC	100.00%	$	$	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%			16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%			17
18	V	17	ADMIN.-M. WOLF		4600 TOUHY, LLC	100.00%			18
19	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	135	135	19
20	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%			20
21	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%			21
22	V	26	INSURANCE		4600 TOUHY, LLC	100.00%			22
23	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	3,593	3,593	23
24	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	4,809	4,809	24
25	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	4,037	4,037	25
26	V								26
27	V								27
28	V								28
29	V	34	RENT	15,704	4600 TOUHY, LLC			(15,704)	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			$ 15,704			$ 12,574	$ * (3,130)	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: 01/01/12 Ending: 12/31/12

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

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

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

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

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

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

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	LINCOLNWOOD	BUILDING CO.	1
2	MOSHE WOLF	1.570%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO.	2
3	DAVIS FAMILY TRUST	10.000%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	INTERCARE, LTD. C/O MANAG	LINCOLNWOOD	MANAGEMENT CO.	3
4	EDIE DAVIS	0.055%			4600 TOUHY, LLC	LINCOLNWOOD	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	1.574%						8
9	SHOSHANA BRAUN	0.555%						9
10	YEHOSHUA DAVIS	0.555%						10
11	YISROEL DAVIS	0.555%						11
12	YOSEF DAVIS DELTA TRUST 7/18/01	82.916%						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: 01/01/12 Ending: 12/31/12

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

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	Relative	Mgmt/Admin	0.00%	See Attached	4.76	15.87%	Alloc. Salary	$ 6,614	17-7	1
2	Moshe Davis	Shareholder	Mgmt/Admin	0.56%	See Attached	7.95	18.07%	Sal./Al.Sal	45,863	17-1, 17-7	2
3	Moshe Wolf	Shareholder	Administrative	1.57%	See Attached	7.23	15.06%	Alloc.Sal/Fees	15,801	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	7.59	18.07%	Alloc. Salary	20,032	17-7	4
5	Nesanel Davis	Shareholder	Administrative	0.56%	See Attached	7.95	0.01%	Alloc. Salary	31,663	17-7	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	$ 119,973		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: 01/01/12 Ending: 12/31/12

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

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

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: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
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	1	DIETARY	PATIENT DAYS	278,486	4	$ 201	$	50,311	$ 36	1
2	3	HOUSEKEEPING	PATIENT DAYS	278,486	4	10,914		50,311	1,972	2
3	5	UTILITIES	PATIENT DAYS	278,486	4	8,439		50,311	1,525	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	278,486	4	73,740		50,311	13,322	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	278,486	4	40,948		50,311	7,398	5
6	17	ADMINISTRATIVE	PATIENT DAYS	278,486	4	723,635	723,635	50,311	130,731	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	278,486	4			50,311		7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	278,486	4	14,497		50,311	2,619	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	278,486	4	672,355	453,150	50,311	121,467	9
10	24	SEMINARS	PATIENT DAYS	278,486	4	2,422		50,311	438	10
11	25	ADMIN. STAFF TRANS.	PATIENT DAYS	278,486	4	1,240		50,311	224	11
12	26	INSURANCE	PATIENT DAYS	278,486	4	1,286		50,311	232	12
13	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	278,486	4	270,942		50,311	48,948	13
14	30	DEPRECIATION	PATIENT DAYS	278,486	4	137,841		50,311	24,783	14
15	32	INTEREST EXPENSE	PATIENT DAYS	278,486	4	3,032		50,311	548	15
16	34	RENT - BUILDING (RELATED)	PATIENT DAYS	278,486	4	86,925		50,311	15,704	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	278,486	4	2,412		50,311	436	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,050,829	$ 1,176,785		$ 370,383	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
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	$ 25,000	$ 25,000	5	$ 6,614	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	18	4			5		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	18	4	85		5	22	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	18	4	38		5	10	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	18	4	1,905		5	504	5
6	30	DEPRECIATION	AVG. HOURS WORKED	18	4			5		6
7	32	INTEREST EXPENSE	AVG. HOURS WORKED	18	4			5		7
8	35	EQUIPMENT RENTAL	AVG. HOURS WORKED	18	4			5		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					$ 27,028	$ 25,000		$ 7,150	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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: 4600 TOUHY, LLC
Street Address: 4600 W. TOUHY AVENUE, SUITE 200
City / State / Zip Code: LINCOLNWOOD, IL 60712
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	278,486	4	$	$	50,311	$	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	278,486	4			50,311		2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	278,486	4			50,311		3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	278,486	4			50,311		4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	278,486	4	750		50,311	135	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	278,486	4			50,311		6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	278,486	4			50,311		7
8	26	INSURANCE	MNGCR. PATIENT DAYS	278,486	4			50,311		8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	278,486	4	19,887		50,311	3,593	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	278,486	4	26,618		50,311	4,809	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	278,486	4	22,347		50,311	4,037	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					$ 69,602	$		$ 12,574	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

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
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14										14
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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: 01/01/12 Ending: 12/31/12

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

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			$	$ 5,404,921			$ 411,198	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				750,000			42,459	6
7	Allocated from 4600 Touhy, LLC										4,809	7
8	See Supplemental Schedule										548	8
9	TOTAL Facility Related						$	$ 6,154,921			$ 459,014	9
	B. Non-Facility Related*											
10	Miscellaneous Interest Expense		X								74,242	10
11	Interest Income		X								(622)	11
12	Interest Income- Building Co.		X								(183)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 73,437	14
15	TOTALS (line 9+line14)						$	$ 6,154,921			$ 532,451	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,545 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: 01/01/12 Ending: 12/31/12

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				$	$			$ 548	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										548	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:** 01/01/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 135,300	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.)		$ 133,825	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,475)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 131,300	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.		$ 129,825	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	54,724	8
	2008	55,272	9
	2009	124,892	10
	2010	130,330	11
	2011	129,788	12

2012 Accrual=$129,788 X 1.01 = $131,300 (Rounded)
Allocated From $4600 Touhy LLC =$4,037

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 1,020.90	$ 1,020.90
2.	16-08-419-003-0000	Long Term Care Property	$ 29,091.84	$ 29,091.84
3.	16-08-419-004-0000	Long Term Care Property	$ 43,388.85	$ 43,388.85
4.	16-08-419-005-0000	Long Term Care Property	$ 29,961.04	$ 29,961.04
5.	16-08-419-006-0000	Long Term Care Property	$ 20,895.87	$ 20,895.87
6.	16-08-419-007-0000	Long Term Care Property	$ 5,429.03	$ 5,429.03
7.	See Attached	Al. From Managcare/4600 Touchy	$ 44,694.09	$ 4,037.19
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 174,481.62	$ 133,824.72

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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: 01/01/12 Ending: 12/31/12

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

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	$ 46,532	30	$ 79,782	$ 33,250	$ 910,970	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	10,021	11
12	Various			1988	38,957		20	1,257	1,257	30,896	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	1,067	1,067	37,428	14
15	Various			1991	34,073		20			34,073	15
16	Various			1992	1,200		20	10	10	1,200	16
17	Various			1993	6,071		20	304	304	5,882	17
18	Various			1994	24,281		20	1,214	1,214	22,129	18
19	Various			1995	1,467		20	73	73	1,277	19
20	Various			1996	64,140		20	3,207	3,207	53,050	20
21	Various			1997	15,923		20	796	796	12,385	21
22	Various			1998	966,314		20	48,316	48,316	684,558	22
23	Various			1999	137,374		20	6,869	6,869	93,733	23
24	Various			2000	43,701		20	1,358	1,358	33,721	24
25	Various			2001	9,572		20	242	242	7,515	25
26	Various			2002	14,269		20	488	488	14,269	26
27	Various			2003	3,119		20	107	107	1,999	27
28	Various			2004	32,093		20	1,687	1,687	19,615	28
29	Various			2005	14,586		20	612	612	10,711	29
30	Various			2006	8,163		20	605	605	5,182	30
31	Various			2007	97,856		20	9,786	9,786	51,674	31
32	Various			2008	188,896		20	18,615	18,615	77,261	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: 01/01/12 Ending: 12/31/12

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)		223,259	10,376		6,822	(3,554)	7,426	68
69	Financial Statement Depreciation			79,365			(79,365)		69
70	TOTAL (lines 4 thru 69)		$ 3,667,115	$ 136,273		$ 183,607	$ 47,334	$ 2,220,719	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: 01/01/12 Ending: 12/31/12

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		$ 3,667,115	$ 136,273		$ 183,607	$ 47,334	$ 2,220,719	1
2	Remote Annunciator	2009	4,575		20	457	457	1,716	2
3	Monitoring System	2009	4,596		20	460	460	1,417	3
4	4Th Flr Call System	2009	7,663		20	1,095	1,095	3,832	4
5	Elevator Valve	2010	3,300		20	165	165	371	5
6	Concrete Parking And Sidewalk	2010	7,500		20	750	750	1,750	6
7	New Generator	2010	81,500		20	4,075	4,075	8,829	7
8	Nurses Call System	2010	15,327		20	3,065	3,065	9,196	8
9	Steinhardt Builders Roof Insulation	2010	5,376		20	538	538	1,165	9
10	Wall-Mounted Sign	2011	8,311		20	831	831	1,108	10
11	East And West Passenger Elevator	2011	78,711		20	3,936	3,936	4,591	11
12	Copper Piping	2011	5,200		20	520	520	823	12
13	Awning	2012	3,000		20	200	200	200	13
14	Lighting For Awning And Parking Lot	2012	2,750		20	504	504	504	14
15	Waunderguard Alert System	2012	5,296		20	883	883	883	15
16	Welding Of 1/2" Square Bars Between Existing Pickets At Two In	2012	4,500		20	375	375	375	16
17	Flooring In Kitchen, Dish Room, Office, And Halls	2012	15,800		20	526	526	526	17
18	Chiller	2012	10,950		20	608	608	608	18
19	Piping And Valves	2012	3,250		20	163	163	163	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)		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	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: 01/01/12 Ending: 12/31/12

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		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	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
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	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: 01/01/12 Ending: 12/31/12

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		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	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: 01/01/12 Ending: 12/31/12

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		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,934,720	$ 136,273		$ 202,757	$ 66,484	$ 2,258,777	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: 01/01/12 Ending: 12/31/12

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
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

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

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
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	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: 01/01/12 Ending: 12/31/12

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 4600 Touchy LLC	2012	92,761	844	30	3,092	2,248	3,092	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:	2012	109,963	2,749	20	2,749		2,749	8
9	Allocated from 4600 Touchy LLC								9
10									10
11	Allocated from Inter Care LTD	2001	1,168		20	58	58	662	11
12									12
13	Allocated From Managcare	2012	19,367	6,783	20	923	(5,860)	923	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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

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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 223,259	$ 10,376		$ 6,822	$ (3,554)	$ 7,426	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: 01/01/12 Ending: 12/31/12

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	$ 363,165	$ 29,031	$ 16,632	$ (12,399)	10	$ 287,943	71
72	Current Year Purchases	70,005	18,794	3,972	(14,822)	10	3,972	72
73	Fully Depreciated Assets	749,816		29	29	10	749,727	73
74								74
75	TOTALS	$ 1,182,987	$ 47,825	$ 20,633	$ (27,192)		$ 1,041,642	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	2012	$ 25,286	$ 3,614	$ 3,468	$ (146)	5	$ 17,508	76
77										77
78										78
79										79
80	TOTALS			$ 25,286	$ 3,614	$ 3,468	$ (146)		$ 17,508	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)	$ 5,311,983	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,712	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,859	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,147	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,317,927	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 436 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: 01/01/12 Ending: 12/31/12

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

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	$		$ 318,332	$		$ 318,332	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			258,695			258,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			348,093			348,093	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				123,319		123,319	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					108,873	97,010		205,883	13
14	TOTAL			$		$ 1,033,993	$ 220,329		$ 1,254,322	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: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 285,276	$ 354,802	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,725,785	2,725,785	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,637	172,915	6
7	Other Prepaid Expenses	4,312	49,583	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	17,093	459,079	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,156,103	$ 3,762,164	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	169,177	1,707,480	15
16	Equipment, at Historical Cost	225,737	1,452,019	16
17	Accumulated Depreciation (book methods)	(204,358)	(2,640,591)	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	81,240	924,904	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 271,796	$ 3,313,451	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,427,899	$ 7,075,615	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,056,705	$ 1,062,855	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,598	55,598	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	149,940	149,940	30
31	Accrued Taxes Payable (excluding real estate taxes)	213,644	213,644	31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,300	32
33	Accrued Interest Payable	3,028	15,414	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,902,791	1,928,598	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,131,706	$ 4,307,349	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,404,921	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)**	$	$ 5,404,921	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,131,706	$ 9,712,270	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (703,807)	$ (2,636,655)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,427,899	$ 7,075,615	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (983,394)	1
2	Restatements (describe):		2
3		1	3
4	**Rounding Adjustment**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (983,393)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	279,586	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)**	$ 279,586	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)**	$ (703,807)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,437,170	1
2	Discounts and Allowances for all Levels	(827,998)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,609,172	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,704,924	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,704,924	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	195,772	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,623	19
20	Radiology and X-Ray	5,420	20
21	Other Medical Services	38,040	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,855	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	623	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 623	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,845	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,845	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,573,419	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,468,438	31
32	Health Care	3,649,642	32
33	General Administration	2,653,584	33
	B. Capital Expense		
34	Ownership	788,783	34
	C. Ancillary Expense		
35	Special Cost Centers	1,377,554	35
36	Provider Participation Fee	355,832	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,293,833	40
41	**Income before Income Taxes (line 30 minus line 40)****	279,586	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 279,586	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,240,655	44
45	Private Pay - Net Inpatient Revenue	132,399	45
46	Medicare - Net Inpatient Revenue	2,107,280	46
47	Other-(specify) Hospice	126,056	47
48	Other-(specify) Insurance	2,782	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,609,172	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,850	2,021	$ 86,175	$ 42.63	1
2	Assistant Director of Nursing	1,356	1,395	54,743	39.24	2
3	Registered Nurses	18,170	19,411	519,060	26.74	3
4	Licensed Practical Nurses	42,745	45,844	1,082,847	23.62	4
5	CNAs & Orderlies	97,053	105,798	1,067,499	10.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,433	10,668	154,906	14.52	8
9	Activity Director	1,915	2,093	31,374	14.99	9
10	Activity Assistants	11,816	12,940	122,934	9.50	10
11	Social Service Workers	10,178	11,058	176,704	15.98	11
12	Dietician					12
13	Food Service Supervisor	2,680	2,845	70,670	24.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,349	23,773	233,924	9.84	15
16	Dishwashers					16
17	Maintenance Workers	10,191	11,186	119,581	10.69	17
18	Housekeepers	19,831	21,324	199,588	9.36	18
19	Laundry	6,978	8,056	85,873	10.66	19
20	Administrator	1,968	2,160	139,706	64.68	20
21	Assistant Administrator					21
22	Other Administrative	216	216	13,929	64.49	22
23	Office Manager					23
24	Clerical	9,055	9,984	146,070	14.63	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	4,049	4,483	61,505	13.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,061	3,357	115,065	34.28	33
34	TOTAL (lines 1 - 33)	274,895	298,613	$ 4,482,153 *	$ 15.01	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	238	$ 11,304	01-03	35
36	Medical Director	Monthly	32,525	09-03	36
37	Medical Records Consultant	Monthly	1,536	10-03	37
38	Nurse Consultant	22	6,625	10-03	38
39	Pharmacist Consultant	Monthly	28,373	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	14,543	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	88	5,096	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	$ 100,002		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shai Berdugo	Administrator	0.00%	$ 139,706
Moshe Davis	Administrative	0.555%	13,929
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 153,635

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
Frost, Ruttenberg & Rothblatt	Accounting	$ 20,250
Managcare, Inc	Bookkeeping	234,000
Managcare, Inc	Computer Serv./Consulting	9,173
Comprehensive Reimbursement	Reimbursement Consulting	10,745
Property Valuation Services	Appraisal (Adj p.5A)	3,000
E-Health Data Solutions	Computer Services	4,583
American Data	Computer Services	4,138
Adar	Computer Services	10,438
Honkamp Krueger	Unemployment Consult	1,553
Personnel Planners	Unemployment Consult	3,373
See Attached	Legal	52,342
Prior Year Legal	Adjusted on Page 5a	13,449
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 367,044

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,078
Unemployment Compensation Insurance	144,739
FICA Taxes	339,255
Employee Health Insurance	194,290
Employee Meals	53,820
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	555
Pension Expense	45,073
Disability Insurance	3,834
Holiday Expense	13,081
Chicago Head Tax	2,938
Other Employee Benefits	3,709
TOTAL (agree to Schedule V, line 22, col.8)	$ 876,372

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	$ 3,980
Advertising: Employee Recruitment	19,819
Health Care Worker Background Check	2,675
(Indicate # of checks performed 86)	
Patient Background Checks 157	1,723
Dues & Subscriptions	13,324
Licenses & Permits	4,007
Advertising	60,878
See Supplemental Schedule	2,641
Less: Public Relations Expense	( )
Non-allowable advertising	(60,878)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,169

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,444
Allocated From Managcare	438
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,882

* Attach copy of IMRF notifications

**See instructions.

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

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

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 $12,554**

(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. $ **58,773** 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. $ **355,826**
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. $ **53,820** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% 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.