FOR BHF USE

LL1

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0029660

Facility Name: Mayfield Care Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1985

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 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: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	156	Skilled (SNF)	156	56,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,034		7,211	31,245	8
9	SNF/PED					9
10	ICF	18,884	288		19,172	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,918	288	7,211	50,417	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.54%

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 01/01/1985

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 [ ] NO [ ] If YES, enter number of beds certified 104 and days of care provided 6,148

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: 12/31/13 Fiscal Year: 12/31/13

* 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: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	293,627	50,370	11,656	355,653		355,653	21	355,674			1
2	Food Purchase		301,501		301,501	(50,881)	250,620	(2,044)	248,576			2
3	Housekeeping	7,988	15,356	311,048	334,392		334,392	1,228	335,620			3
4	Laundry	6,343	15,450	208,356	230,149		230,149		230,149			4
5	Heat and Other Utilities			144,663	144,663		144,663	(3,485)	141,178			5
6	Maintenance	132,615	29,232	53,928	215,775		215,775	19,181	234,956			6
7	Other (specify):*											7
8	TOTAL General Services	440,573	411,909	729,651	1,582,133	(50,881)	1,531,252	14,901	1,546,153			8
	B. Health Care and Programs											
9	Medical Director			55,750	55,750		55,750	13,898	69,648			9
10	Nursing and Medical Records	2,959,096	162,095	154,849	3,276,040		3,276,040	58,678	3,334,718			10
10a	Therapy	140,591		6,112	146,703		146,703		146,703			10a
11	Activities	160,586	17,540	5,424	183,550		183,550		183,550			11
12	Social Services	157,131		9,429	166,560		166,560	1,683	168,243			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,197	10,197			15
16	TOTAL Health Care and Programs	3,417,404	179,635	231,564	3,828,603		3,828,603	84,456	3,913,059			16
	C. General Administration											
17	Administrative	116,720		230,544	347,264		347,264	(123,644)	223,620			17
18	Directors Fees											18
19	Professional Services			370,050	370,050	(462)	369,588	(274,577)	95,012			19
20	Dues, Fees, Subscriptions & Promotions			126,865	126,865		126,865	(70,783)	56,082			20
21	Clerical & General Office Expenses	206,638	29,379	1,025,894	1,261,911		1,261,911	(832,930)	428,981			21
22	Employee Benefits & Payroll Taxes			798,919	798,919	50,881	849,800		849,800			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,350	1,350		1,350	74	1,424			24
25	Other Admin. Staff Transportation			4,019	4,019		4,019	2,597	6,616			25
26	Insurance-Prop.Liab.Malpractice			12,306	12,306		12,306	154,245	166,551			26
27	Other (specify):*							34,966	34,966			27
28	TOTAL General Administration	323,358	29,379	2,569,947	2,922,684	50,419	2,973,103	(1,110,052)	1,863,051			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,181,335	620,923	3,531,162	8,333,420	(462)	8,332,958	(1,010,694)	7,322,264			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: 01/01/13 Ending: 12/31/13

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			33,868	33,868		33,868	194,895	228,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,230	83,230		83,230	135,703	218,933			32
33	Real Estate Taxes			755	755	462	1,217	191,945	193,162			33
34	Rent-Facility & Grounds			481,100	481,100		481,100	(481,100)	(0)			34
35	Rent-Equipment & Vehicles			6,940	6,940		6,940	(3,381)	3,559			35
36	Other (specify):*			145,356	145,356		145,356	26,868	172,224			36
37	**TOTAL Ownership**			751,249	751,249	462	751,711	64,930	816,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		280,116	1,186,604	1,466,720		1,466,720	(4,667)	1,462,053			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			354,111	354,111		354,111		354,111			42
43	Other (specify):*	84,333		5,406	89,739		89,739	(89,739)	(0)			43
44	**TOTAL Special Cost Centers**	84,333	280,116	1,546,121	1,910,570		1,910,570	(94,406)	1,816,164			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,265,668	901,039	5,828,532	10,995,239		10,995,239	(1,040,170)	9,955,069			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: 01/01/13 Ending: 12/31/13

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	(5,462)	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	68,381	30		9
10	Interest and Other Investment Income	(16,748)	32		10
11	Discounts, Allowances, Rebates & Refunds	(318)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	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	(115)	21		18
19	Entertainment				19
20	Contributions	(42,730)	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	(925,484)	21		24
25	Fund Raising, Advertising and Promotional	(35,725)	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	(200,023)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,158,241)		$	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)	118,071		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 118,071		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,040,170)		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

STATE OF ILLINOIS **Page 5A**

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Peroid - Professional Fees	$ (30,333)	19	1
2	Prior Peroid - General & Administrative	(2,950)	21	2
3	Vending Income	(1,607)	02	3
4	Marketing Consultant	(5,374)	43	4
5	Bank Charges	(4,830)	21	5
6	Marketing Salaries	(69,663)	43	6
7	Theft and Loss	(97)	21	7
8	COPE Dues	(6,363)	20	8
9	Building Company - Professional Fees	(13,686)	19	9
10	Building Company - Annual Report	(100)	20	10
11	Building Company - Accounting Fees	(10,475)	19	11
12	Building Company - Amortization	(2,343)	36	12
13	Additional R&M	14,461	06	13
14	Non-allowable Auto Lease	(6,940)	35	14
15	Marketing	(32)	43	15
16	Non-allowable Seminar	(521)	24	16
17	Non-allowable Legal	(2,049)	19	17
18	Sequester	(41,702)	21	18
19	Food Rebate	(420)	02	19
20	Prior Period - X Ray Services	(330)	39	20
21	Non Allowable Salary	(14,670)	43	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(200,023)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mayfield Care Center **#** 0029660 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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			21									21	1
2	Food Purchase	(2,044)											(2,044)	2
3	Housekeeping			1,228									1,228	3
4	Laundry													4
5	Heat and Other Utilities	(5,462)		1,490		487							(3,485)	5
6	Maintenance	14,461		3,828		892							19,181	6
7	Other (specify):*													7
8	**TOTAL General Services**	6,955		6,567		1,379							14,901	8
	B. Health Care and Programs													
9	Medical Director			13,898									13,898	9
10	Nursing and Medical Records			58,678									58,678	10
10a	Therapy													10a
11	Activities													11
12	Social Services			1,683									1,683	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			10,197									10,197	15
16	**TOTAL Health Care and Programs**			84,456									84,456	16
	C. General Administration													
17	Administrative			36,605	63,587		(223,836)						(123,644)	17
18	Directors Fees													18
19	Professional Services	(56,543)	24,161	(177,514)	(65,307)	626							(274,577)	19
20	Fees, Subscriptions & Promotions	(84,918)	100	13,870		104	61						(70,783)	20
21	Clerical & General Office Expenses	(975,496)	(6)	142,515	26	31							(832,930)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(521)		594									74	24
25	Other Admin. Staff Transportation			1,567	2		1,027						2,597	25
26	Insurance-Prop.Liab.Malpractice		153,607	399		239							154,245	26
27	Other (specify):*			29,159	5,808								34,966	27
28	**TOTAL General Administration**	(1,117,478)	177,862	47,195	4,117	1,000	(222,748)						(1,110,052)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,110,522)	177,862	138,218	4,117	2,379	(222,748)						(1,010,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	68,381	113,581	10,023		2,910							194,895	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,748)	147,029	36		5,386							135,703	32
33	Real Estate Taxes		189,282			2,663							191,945	33
34	Rent-Facility & Grounds		(481,100)	15,748		(15,748)							(481,100)	34
35	Rent-Equipment & Vehicles	(6,940)		165	3,393								(3,381)	35
36	Other (specify):*	(2,343)	29,211										26,868	36
37	**TOTAL Ownership**	42,350	(1,997)	25,972	3,393	(4,788)							64,930	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(330)						(4,337)					(4,667)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(89,739)											(89,739)	43
44	**TOTAL Special Cost Centers**	(90,069)						(4,337)					(94,406)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,158,241)	175,865	164,190	7,510	(2,409)	(222,748)	(4,337)					(1,040,170)	45

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 481,100	Mayfield Building Limited Partnership	100.00%	$	$ (481,100)	1
2	V	32	Interest Income	219	Mayfield Building Limited Partnership	100.00%		(219)	2
3	V	21	Other Income	6	Mayfield Building Limited Partnership	100.00%		(6)	3
4	V	19	Professional Fees		Mayfield Building Limited Partnership	100.00%	13,686	13,686	4
5	V	32	Interest Expense		Mayfield Building Limited Partnership	100.00%	147,248	147,248	5
6	V	26	Insurance		Mayfield Building Limited Partnership	100.00%	153,607	153,607	6
7	V	20	Annual Report		Mayfield Building Limited Partnership	100.00%	100	100	7
8	V	30	Depreciation Expense		Mayfield Building Limited Partnership	100.00%	113,581	113,581	8
9	V	33	Real Estate Taxes		Mayfield Building Limited Partnership	100.00%	189,282	189,282	9
10	V	36	FHA Mortgage Insurance		Mayfield Building Limited Partnership	100.00%	26,868	26,868	10
11	V	19	Accounting Fees		Mayfield Building Limited Partnership	100.00%	10,475	10,475	11
12	V	36	Amortization		Mayfield Building Limited Partnership	100.00%	2,343	2,343	12
13	V								13
14	Total			$ 481,325			$ 657,190	$ * 175,865	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: 01/01/13 Ending: 12/31/13

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%	$ 21	$ 21	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,228	1,228	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,490	1,490	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	3,828	3,828	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	13,898	13,898	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	58,678	58,678	20
21	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	1,683	1,683	21
22	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	10,197	10,197	22
23	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	36,605	36,605	23
24	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,325	1,325	24
25	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	13,870	13,870	25
26	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	107,250	107,250	26
27	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	35,264	35,264	27
28	V	24	SEMINARS		MANAGCARE, INC.	100.00%	594	594	28
29	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	1,567	1,567	29
30	V	26	INSURANCE		MANAGCARE, INC.	100.00%	399	399	30
31	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	29,159	29,159	31
32	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	10,023	10,023	32
33	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	36	36	33
34	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	15,748	15,748	34
35	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	165	165	35
36	V								36
37	V	19	BOOKKEEPING/CONSULTING	178,839	MANAGCARE, INC.	100.00%		(178,839)	37
38	V								38
39	Total			$ 178,839			$ 343,029	$ * 164,190	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: 01/01/13 Ending: 12/31/13

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 SALARY - NATH	$	TETRAD MANAGEMENT, LLC	100.00%	$ 19,732	$ 19,732	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	6,782	6,782	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	19,732	19,732	17
18	V	17	ADMINISTRATIVE FEES - YOSEF DAVIS		TETRAD MANAGEMENT, LLC	100.00%	17,341	17,341	18
19	V								19
20	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	155	155	20
21	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	26	26	21
22	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2	2	22
23	V	27	EMPLOYEE BEENFITS- PAYROLL TAXES		TETRAD MANAGEMENT, LLC	100.00%	5,808	5,808	23
24	V	35	AUTO LEASE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	3,393	3,393	24
25	V								25
26	V								26
27	V	19	ADMINISTRATIVE CONSULTING	65,462	TETRAD MANAGEMENT, LLC	100.00%		(65,462)	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			$ 65,462			$ 72,972	$ * 7,510	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: 01/01/13 Ending: 12/31/13

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	5	UTILITIES	$	4600 TOUHY, LLC	100.00%	$ 487	$ 487	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	892	892	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	626	626	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	104	104	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	31	31	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	239	239	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,910	2,910	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,386	5,386	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	2,663	2,663	23
24	V								24
25	V	34	RENT	15,748	4600 TOUHY, LLC	100.00%		(15,748)	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			$ 15,748			$ 13,339	$ * (2,409)	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: 01/01/13 Ending: 12/31/13

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%	$ 6,708	$ 6,708	15
16	V								16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	61	61	17
18	V								18
19	V	25	ADMIN. STAFF TRAVEL		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,027	1,027	19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	230,544	INTERCARE, LTD. C/O MANAGCARE	100.00%		(230,544)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 230,544			$ 7,796	$ * (222,748)	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: 01/01/13 Ending: 12/31/13

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	39	AMBULANCE	$ 24,812	LIFELINE AMBULANCE	100.00%	$ 20,475	$ (4,337)	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			$ 24,812			$ 20,475	$ * (4,337)	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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	0.56%	BRIGHTVIEW CARE CENTER, INC	CHICAGO	MAYFIELD BUILDING LIMITEI	LINCOLNWOOD	BUILDING CO.	1
2	MOSHE WOLF	1.57%	LAKE SHORE HEALTHCARE & REHABILITATION CENTRE,LLC	CHICAGO	MANAGCARE, INC.	LINCOLNWOOD	MANAGEMENT CO.	2
3	DAVIS FAMILY TRUST	10.00%	MID AMERICA CARE CENTER, L.L.C.	CHICAGO	INTERCARE, LTD. C/O MANAG	LINCOLNWOOD	MANAGEMENT CO.	3
4	EDIE DAVIS	0.06%	CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	4
5	ELIYAHU DAVIS	0.56%	COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO.	5
6	MOSHE DAVIS	0.56%	THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS	LIFELINE AMBULANCE	CHICAGO	AMBULANCE SERVICES	6
7	NESANEL DAVIS	0.56%	MORTON TERRACE HEALTHCARE & REHAB CTR., LLC	MORTON				7
8	RENITA O'CONNELL	1.57%	MORTON VILLA HEALTHCARE & REHABILITATION CTR., LLC	MORTON				8
9	SHOSHANA BRAUN	0.56%	RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				9
10	YEHOSHUA DAVIS	0.56%						10
11	YISROEL DAVIS	0.56%						11
12	YOSEF DAVIS DELTA TRUST 7/18/01	82.92%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		See Attached	1.86	6.20%	Alloc Sal / Fees	$ 24,049	17-7	1
2	Moshe Davis	Shareholder	Mgmt/Admin	56%	See Attached	4.56	10%	Alloc. Salary	19,732	17-7	2
3	Nesanel Davis	Shareholder	Administrative	56%	See Attached	4.97	10%	Alloc. Salary	19,732	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	4.35	10%	Alloc. Salary	9,967	17-7	4
5	Moshe Wolf	Shareholder	Administrative	1.57%	See Attached	4.97	10%	Alloc. Salary	8,707	17-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 82,187		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	486,626	10	$ 198	$	50,417	$ 21	1
2	3	HOUSEKEEPING	PATIENT DAYS	486,626	10	11,856		50,417	1,228	2
3	5	UTILITIES	PATIENT DAYS	486,626	10	14,381		50,417	1,490	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	486,626	10	36,948		50,417	3,828	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	486,626	10	134,142		50,417	13,898	5
6	10	NURSING SALARIES	PATIENT DAYS	486,626	10	566,366	566,366	50,417	58,678	6
7	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	486,626	10	16,247	16,247	50,417	1,683	7
8	15	NURSING EMP BENS & PR TA	PATIENT DAYS	486,626	10	98,421		50,417	10,197	8
9	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	486,626	10	353,309	353,309	50,417	36,605	9
10	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	12,785		50,417	1,325	10
11	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	486,626	10	133,874		50,417	13,870	11
12	21	CLERICAL AND GENERAL SA	PATIENT DAYS	486,626	10	1,035,183	1,035,183	50,417	107,250	12
13	21	CLERICAL AND GENERAL EX	PATIENT DAYS	486,626	10	340,374		50,417	35,264	13
14	24	SEMINARS	PATIENT DAYS	486,626	10	5,737		50,417	594	14
15	25	ADMIN. STAFF TRANS.	PATIENT DAYS	486,626	10	15,128		50,417	1,567	15
16	26	INSURANCE	PATIENT DAYS	486,626	10	3,851		50,417	399	16
17	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	486,626	10	281,440		50,417	29,159	17
18	30	DEPRECIATION	PATIENT DAYS	486,626	10	96,741		50,417	10,023	18
19	32	INTEREST EXPENSE	PATIENT DAYS	486,626	10	346		50,417	36	19
20	34	RENT - BUILDING (RELATED)	PATIENT DAYS	486,626	10	152,000		50,417	15,748	20
21	35	EQUIPMENT RENTAL	PATIENT DAYS	486,626	10	1,597		50,417	165	21
22										22
23										23
24										24
25	TOTALS					$ 3,310,923	$ 1,971,105		$ 343,029	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: TETRAD MANAGEMENT, 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	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	$ 190,457	$ 190,457	50,417	$ 19,732	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	65,457	65,457	50,417	6,782	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	486,626	10	190,457	190,457	50,417	19,732	3
4	17	ADMINISTRATIVE FEES - YO	PATIENT DAYS	486,626	10	167,375		50,417	17,341	4
5	17	TOTAL MANAGEMENT FEES	PATIENT DAYS	486,626	10			50,417		5
6	19	PROFESSIONAL FEES	PATIENT DAYS	486,626	10	1,500		50,417	155	6
7	21	OFFICE EXPENSE	PATIENT DAYS	486,626	10	253		50,417	26	7
8	25	TRAVEL	PATIENT DAYS	486,626	10	23		50,417	2	8
9	27	EMPLOYEE BEENFITS- PAYE	PATIENT DAYS	486,626	10	56,057		50,417	5,808	9
10	35	AUTO LEASE EXPENSE	PATIENT DAYS	486,626	10	32,750		50,417	3,393	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					$ 704,328	$ 446,371		$ 72,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	5	UTILITIES	MNGCR. PATIENT DAYS	486,626	10	$ 4,702	$	50,417	$ 487	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	486,626	10	8,610		50,417	892	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	486,626	10	6,043		50,417	626	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	486,626	10	1,001		50,417	104	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	486,626	10	300		50,417	31	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	486,626	10	2,308		50,417	239	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	486,626	10	28,092		50,417	2,910	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	486,626	10	51,990		50,417	5,386	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	486,626	10	25,708		50,417	2,663	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					$ 128,752	$		$ 13,339	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	187,889	3	$ 25,000	$ 25,000	50,417	$ 6,708	1
2										2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	187,889	3	228		50,417	61	3
4										4
5	25	ADMIN. STAFF TRAVEL	AVG. HOURS WORKED	187,889	3	3,826		50,417	1,027	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					$ 29,054	$ 25,000		$ 7,796	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: LIFELINE AMBULANCE LLC
Street Address: 2424 S. WABASH AVENUE
City / State / Zip Code: CHICAGO, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	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	39	AMBULANCE	DIRECT COST			$	$		$ 20,475	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					$	$		$ 20,475	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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		X	Mortgage			$	$ 5,311,392			$ 147,248	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				1,481,352			52,984	6
7	Allocated from Managcare		X								36	7
8	See Supplemental Schedule										5,386	8
9	TOTAL Facility Related						$	$ 6,792,743			$ 205,654	9
	B. Non-Facility Related*											
10	Interest Expense		X								30,246	10
11	Interest Income		X								(16,748)	11
12	Interest Income - Building Co.		X								(219)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 13,280	14
15	TOTALS (line 9+line14)						$	$ 6,792,743			$ 218,933	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,868 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: 01/01/13 Ending: 12/31/13

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 4600 Touhy		X				$	$			$ 5,386	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5,386	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: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 131,300	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.)		$ 162,099	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,799	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 161,900	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.)**		$ 462	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** $ 96 **For** 2003 **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.		$ 193,161	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	55,272	8
	2009	124,892	9
	2010	130,330	10
	2011	129,788	11
	2012	159,436	12

2013 Accrual = $159,436 x 1.02 = $161,900 (Rounded)

Allocated from 4600 Touhy LLC = $2,663

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-08-419-003-0000	Long Term Care Property	$ 35,799.69	$ 35,799.69
2.	16-08-419-004-0000	Long Term Care Property	$ 53,599.31	$ 53,599.31
3.	16-08-419-005-0000	Long Term Care Property	$ 36,986.72	$ 36,986.72
4.	16-08-419-006-0000	Long Term Care Property	$ 25,593.72	$ 25,593.72
5.	16-08-419-007-0000	Long Term Care Property	$ 6,702.88	$ 6,702.88
6.	16-08-419-002-0000	Long Term Care Property	$ 753.70	$ 753.70
7.	See Attached	Alloc. From 4600 Touchy	$ 48,715.81	$ 2,523.61
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 208,151.83	$ 161,959.63

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	$ 113,581	35	$ 79,782	$ (33,799)	$ 990,752	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	10,412	11
12	Various			1988	38,957		20	1,257	1,257	32,153	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	1,067	1,067	38,496	14
15	Various			1991	34,073		20			34,073	15
16	Various			1992	1,200		20			1,200	16
17	Various			1993	6,071		20	189	189	6,071	17
18	Various			1994	24,281		20	1,214	1,214	23,343	18
19	Various			1995	1,467		20	73	73	1,350	19
20	Various			1996	64,140		20	3,207	3,207	56,257	20
21	Various			1997	15,923		20	796	796	13,181	21
22	Various			1998	966,314		20	48,316	48,316	732,873	22
23	Various			1999	137,374		20	6,869	6,869	100,601	23
24	Various			2000	43,701		20	1,358	1,358	35,078	24
25	Various			2001	9,572		20	242	242	7,757	25
26	Various			2002	14,269		20			14,269	26
27	Various			2003	3,119		20	107	107	2,106	27
28	Various			2004	32,093		20	1,687	1,687	21,302	28
29	Various			2005	14,586		20	319	319	11,030	29
30	Various			2006	8,163		20	605	605	5,787	30
31	Various			2007	97,856		20	9,786	9,786	61,459	31
32	Various			2008	188,896		20	18,615	18,615	95,876	32
33	Various			2009	16,834		20	2,012	2,012	8,976	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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)		108,976	4,611		4,562	(49)	9,275	68
69	Financial Statement Depreciation			33,868			(33,868)		69
70	TOTAL (lines 4 thru 69)		$ 3,569,666	$ 152,060		$ 182,453	$ 30,393	$ 2,407,423	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: 01/01/13 Ending: 12/31/13

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		$ 3,569,666	$ 152,060		$ 182,453	$ 30,393	$ 2,407,423	1
2	Elevator Valve	2010	3,300		20	165	165	536	2
3	Concrete Parking And Sidewalk	2010	7,500		20	750	750	2,500	3
4	New Generator	2010	81,500		20	4,075	4,075	12,904	4
5	Nurses Call System	2010	15,327		20	3,065	3,065	12,261	5
6	Steinhardt Builders Roof Insulation	2010	5,376		20	538	538	1,702	6
7	Wall-Mounted Sign	2011	8,311		20	831	831	1,939	7
8	East And West Passenger Elevator	2011	78,711		20	3,936	3,936	8,527	8
9	Copper Piping	2011	5,200		20	520	520	1,343	9
10	Awning	2012	3,000		20	300	300	500	10
11	Lighting For Awning & Patio	2012	2,750		20	100	100	192	11
12	Wanderguard Alert System	2012	5,296		20	1,059	1,059	1,942	12
13	Welding Of 1/2" Square Bars Between Existing Pickets At Two Int	2012	4,500		20	450	450	825	13
14	Flooring In Kitchen, Dish Room, Office, And Halls	2012	15,800		20	1,580	1,580	1,778	14
15	Piping & Valves	2012	3,250		20	163	163	325	15
16	Chiller	2012	10,950		20	913	913	1,521	16
17	Installed New Water Cooled Condensing Unit, Line Vset, Digital D	2013	4,300		20	410	410	410	17
18	Asphalt Area Around Sewer	2013	5,675		20	284	284	284	18
19	Installed New 4 Inch Cast-Iron Pipe With New Pvc Pipe And Fittin	2013	4,750		20	158	158	158	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)		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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: 01/01/13 Ending: 12/31/13

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		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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: 01/01/13 Ending: 12/31/13

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		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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)		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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: 01/01/13 Ending: 12/31/13

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		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,835,162	$ 152,060		$ 201,748	$ 49,688	$ 2,457,070	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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: 01/01/13 Ending: 12/31/13

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 Touhy	2012	53,197	1,364	20	1,773	409	3,546	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Managcare	2012	11,107	1,191	20	555	(636)	1,111	9
10	Allocated from Managcare	2013	893	509	20	45	(464)	45	10
11									11
12	Allocated from 4600 Touhy	2012	34,259	896	20	1,713	817	3,426	12
13	Allocated from 4600 Touhy	2013	8,336	651	20	417	(234)	417	13
14									14
15	Allocated from Intercare, LTD	2001	1,184		20	59	59	730	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: 01/01/13 Ending: 12/31/13

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
13									13
14									14
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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 (12H & 12I lines 1 thru 33)		$ 108,976	$ 4,611		$ 4,562	$ (49)	$ 9,275	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: 01/01/13 Ending: 12/31/13

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	$ 422,978	$ 2,415	$ 23,637	$ 21,222	10	$ 310,613	71
72	Current Year Purchases	21,722	5,130	1,947	(3,183)	10	1,947	72
73	Fully Depreciated Assets	730,482		10	10	10	730,482	73
74								74
75	TOTALS	$ 1,175,183	$ 7,545	$ 25,594	$ 18,049		$ 1,043,042	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	$ 12,521	$ 778	$ 1,421	$ 643	5	$ 10,029	76
77										77
78										78
79										79
80	TOTALS			$ 12,521	$ 778	$ 1,421	$ 643		$ 10,029	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)	$ 5,191,856	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,383	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,764	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68,381	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,510,141	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	Econocare	$ 81,240	92
93			93
94			94
95		$ 81,240	95

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] 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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 165 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	Allocated from Tetrad		$	$ 3,393	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,393	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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 378,537	$		$ 378,537	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			287,345			287,345	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			456,999			456,999	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				164,844		164,844	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					63,723	115,272		178,995	13
14	TOTAL			$		$ 1,186,604	$ 280,116		$ 1,466,720	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: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 70,820	$ 244,275	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,188,780	3,188,780	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,771	220,518	6
7	Other Prepaid Expenses	18,443	18,443	7
8	Accounts Receivable (owners or related parties)	44,569	44,569	8
9	Other(specify): See Attached Schedule	534,396	553,496	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,984,779	$ 4,270,081	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	184,342	1,722,645	15
16	Equipment, at Historical Cost	253,251	1,479,533	16
17	Accumulated Depreciation (book methods)	(238,226)	(2,788,040)	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	1,290,613	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 280,607	$ 3,574,390	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,265,386	$ 7,844,471	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,399,876	$ 1,576,310	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,833	46,833	28
29	Short-Term Notes Payable	1,481,352	1,481,352	29
30	Accrued Salaries Payable	176,335	176,335	30
31	Accrued Taxes Payable (excluding real estate taxes)	106,845	106,845	31
32	Accrued Real Estate Taxes(Sch.IX-B)		161,900	32
33	Accrued Interest Payable	6,346	18,518	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,139,668	2,165,569	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,357,255	$ 5,733,662	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,311,392	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,311,392	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,357,255	$ 11,045,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,091,869)	$ (3,200,583)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,265,386	$ 7,844,471	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (703,807)	1
2	Restatements (describe):		2
3	**Prior Peroid Adjustment**	51,084	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (652,723)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(439,146)	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)**	$ (439,146)	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)**	$ (1,091,869)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 9,608,155	1
2	Discounts and Allowances for all Levels	(1,438,857)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,169,298	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,079,697	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,079,697	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	168,954	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,588	19
20	Radiology and X-Ray	3,485	20
21	Other Medical Services	97,882	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 287,909	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,748	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,748	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,441	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,441	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,556,093	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,582,133	31
32	Health Care	3,828,603	32
33	General Administration	2,922,684	33
	B. Capital Expense		
34	Ownership	751,249	34
	C. Ancillary Expense		
35	Special Cost Centers	1,556,459	35
36	Provider Participation Fee	354,111	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,995,239	40
41	**Income before Income Taxes (line 30 minus line 40)****	(439,146)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (439,146)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,637,071	44
45	Private Pay - Net Inpatient Revenue	115,687	45
46	Medicare - Net Inpatient Revenue	2,263,768	46
47	Other-(specify) Hospice	141,772	47
48	Other-(specify) Insurance	11,000	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,169,298	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: 01/01/13 Ending: 12/31/13

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	1,928	2,099	$ 88,729	$ 42.27	1
2	Assistant Director of Nursing	1,832	1,971	76,960	39.05	2
3	Registered Nurses	12,365	13,211	396,255	29.99	3
4	Licensed Practical Nurses	46,430	49,942	1,247,994	24.99	4
5	CNAs & Orderlies	96,459	106,854	1,111,062	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,932	9,084	140,591	15.48	8
9	Activity Director	1,888	2,139	32,759	15.32	9
10	Activity Assistants	12,043	13,099	127,827	9.76	10
11	Social Service Workers	8,713	9,731	157,131	16.15	11
12	Dietician					12
13	Food Service Supervisor	4,019	4,510	89,133	19.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,893	21,244	204,494	9.63	15
16	Dishwashers					16
17	Maintenance Workers	9,919	11,050	132,615	12.00	17
18	Housekeepers	794	854	7,988	9.35	18
19	Laundry	647	647	6,343	9.80	19
20	Administrator	2,064	2,136	116,720	54.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,649	9,319	206,638	22.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,713	2,713	38,096	14.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,155	2,337	84,333	36.09	33
34	TOTAL (lines 1 - 33)	240,443	262,940	$ 4,265,668 *	$ 16.22	34

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

** See instructions.

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	Monthly	$ 11,656	01-03	35
36	Medical Director	Monthly	55,750	09-03	36
37	Medical Records Consultant	Quarterly	1,536	10-03	37
38	Nurse Consultant	Monthly	118,989	10-03	38
39	Pharmacist Consultant	Monthly	9,988	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	6,112	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	94	5,424	11-03	44
45	Social Service Consultant	Monthly	9,429	12-03	45
46	Other(specify)				46
47					47
48	MDS Consultant	Monthly	24,336	10-03	48
49	TOTAL (lines 35 - 48)	94	$ 243,220		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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shai Berdugo (Term. 4/5/13)	Administrator	0	$ 43,186
William Pfeiffer (Start 4/3/13)	Administrator	0	73,534
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,720

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Managcare, Inc.	Bookkeeping	$ 177,840
Personnel Planners	Unemployment Consulting	2,753
MTS Consulting	Tax Consulting	7,445
FR&R	Accounting	21,041
Legal	See Attached	8,753
Ability Network	Billing Software	843
ADAR, LLC	Cloud Based IT Solutions	12,362
American Data	Electronic Charting System	5,829
eHealth Data Solutions	MDS Software	4,200
Galaxy Hosted Software	Clinical & Financial Software	8,220
Tetrad Management	Administrative Consultant	65,462
See Supplemental Schedule		55,302
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 370,049

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 125,161
Unemployment Compensation Insurance	146,030
FICA Taxes	320,527
Employee Health Insurance	43,142
Employee Meals	50,881
Illinois Municipal Retirement Fund (IMRF)*	
Health and Welfare	114,610
Dental Insurance	434
Employee Benefits	17,444
Pension	23,458
Disability Insurance	2,171
Holiday Expense	3,766
See Supplemental Schedule	2,176
TOTAL (agree to Schedule V, line 22, col.8)	$ 849,802

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	$ 834
Advertising: Employee Recruitment	10,825
Health Care Worker Background Check	3,055
(Indicate # of checks performed 99)	
Patient Background Checks 178	1,953
Licenses and Permits	2,418
Dues and Subcriptions	22,962
Allocated from Managcare	13,870
Allocated from 4600 Touhy	104
See Supplemental Schedule	61
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	829
Allocated from Managcare	594
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,423

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/13 Ending: 12/31/13

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:** 01/01/13 **Ending:** 12/31/13

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. **ICLTC $16,001**

(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. $ **47,635** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **354,111**
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. $ **50,881** 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 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.