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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	25,996		5,869	31,865	8
9	SNF/PED					9
10	ICF	20,425	406		20,831	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,421	406	5,869	52,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.55%

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 [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 4,753

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	288,858	84,085	16,325	389,268		389,268	81	389,349			1
2	Food Purchase		284,988		284,988	(46,227)	238,761	(2,020)	236,740			2
3	Housekeeping		18,281	321,376	339,657		339,657	1,369	341,026			3
4	Laundry		15,639	213,380	229,019		229,019		229,019			4
5	Heat and Other Utilities			160,955	160,955		160,955	(4,875)	156,080			5
6	Maintenance	105,339	24,511	153,023	282,873		282,873	(23,823)	259,050			6
7	Other (specify):*											7
8	**TOTAL General Services**	394,197	427,504	865,059	1,686,760	(46,227)	1,640,533	(29,268)	1,611,264			8
	B. Health Care and Programs											
9	Medical Director			77,685	77,685		77,685	7,908	85,593			9
10	Nursing and Medical Records	3,190,235	173,914	82,661	3,446,810		3,446,810	55,829	3,502,639			10
10a	Therapy	127,497		821	128,318		128,318		128,318			10a
11	Activities	149,679	13,794	7,132	170,605		170,605	15	170,620			11
12	Social Services	146,432		9,400	155,832		155,832	5,370	161,202			12
13	CNA Training											13
14	Program Transportation			25,540	25,540		25,540	(4,316)	21,224			14
15	Other (specify):*							5,311	5,311			15
16	**TOTAL Health Care and Programs**	3,613,843	187,708	203,239	4,004,790		4,004,790	70,117	4,074,907			16
	C. General Administration											
17	Administrative	108,764		230,544	339,308		339,308	(18,152)	321,156			17
18	Directors Fees											18
19	Professional Services			565,369	565,369	(24,818)	540,551	(337,624)	202,927			19
20	Dues, Fees, Subscriptions & Promotions			116,302	116,302		116,302	(75,958)	40,344			20
21	Clerical & General Office Expenses	288,953	24,058	919,226	1,232,237		1,232,237	(743,197)	489,040			21
22	Employee Benefits & Payroll Taxes			821,253	821,253	46,227	867,480		867,480			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,622	1,622		1,622	159	1,781			24
25	Other Admin. Staff Transportation			5,788	5,788		5,788	3,901	9,689			25
26	Insurance-Prop.Liab.Malpractice			179,966	179,966		179,966	9,788	189,754			26
27	Other (specify):*							46,655	46,655			27
28	**TOTAL General Administration**	397,717	24,058	2,840,070	3,261,845	21,410	3,283,255	(1,114,428)	2,168,827			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,405,757	639,270	3,908,368	8,953,395	(24,818)	8,928,577	(1,073,579)	7,854,998			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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: 01/01/14 Ending: 12/31/14

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			52,560	52,560		52,560	208,357	260,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,223	83,223		83,223	111,842	195,065			32
33	Real Estate Taxes			47,829	47,829	24,818	72,647	121,763	194,410			33
34	Rent-Facility & Grounds			582,436	582,436		582,436	(582,436)				34
35	Rent-Equipment & Vehicles							434	434			35
36	Other (specify):*							26,298	26,298			36
37	**TOTAL Ownership**			766,048	766,048	24,818	790,866	(113,742)	677,124			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,806	1,150,718	1,298,524		1,298,524	(30,792)	1,267,732			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			374,973	374,973		374,973		374,973			42
43	Other (specify):*	43,327		29,680	73,007		73,007	(73,007)	0			43
44	**TOTAL Special Cost Centers**	43,327	147,806	1,555,371	1,746,504		1,746,504	(103,799)	1,642,705			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,449,084	787,076	6,229,787	11,465,947		11,465,947	(1,291,120)	10,174,827			45

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(6,896)	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	77,996	30		9
10	Interest and Other Investment Income	(5,158)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,614)	21		18
19	Entertainment				19
20	Contributions	(48,379)	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	(775,951)	21		24
25	Fund Raising, Advertising and Promotional	(22,885)	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	(327,130)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,112,039)		$	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)	(179,081)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (179,081)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,291,120)		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

STATE OF ILLINOIS **Page 5A**

Mayfield Care Center

ID# **0029660**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Expense - A & G	$ (9,047)	21	1
2	Prior Period Expense - Centrad	(30,792)	39	2
3	Vending Income	(1,648)	02	3
4	Jury Duty	(69)	10	4
5	Marketing Consultant	(29,679)	43	5
6	Bank Charges	(6,397)	21	6
7	Marketing Salaries	(43,328)	43	7
8	Theft and Loss	(3,432)	21	8
9	Sequestration	(62,230)	21	9
10	Building Company - Bank Charges	(275)	21	10
11	Building Company - Professional & Accounting Fees	(15,313)	19	11
12	Building Company - Annual Report	(150)	21	12
13	Building Company - Amortization Expense	(2,396)	31	13
14	Building Company - Entity Expense	(1,500)	21	14
15	Non-allowable Interest Expense	(32,732)	32	15
16	PAC Dues	(8,854)	20	16
17	Capitalized R&M	(58,848)	06	17
18	Additional R&M	19,551	06	18
19	Non-allowable Legal	(39,991)	19	19
20	Food Rebate	(350)	02	20
21	Real Estate Taxes	349	33	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**	(327,130)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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			81									81	1
2	Food Purchase	(2,020)											(2,020)	2
3	Housekeeping			1,369									1,369	3
4	Laundry													4
5	Heat and Other Utilities	(6,896)		1,450	571								(4,875)	5
6	Maintenance	(39,297)	10,122	5,132	220								(23,823)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(48,213)	10,122	8,032	791								(29,268)	8
	B. Health Care and Programs													
9	Medical Director			7,908									7,908	9
10	Nursing and Medical Records	(69)		55,898									55,829	10
10a	Therapy													10a
11	Activities			15									15	11
12	Social Services			5,370									5,370	12
13	CNA Training													13
14	Program Transportation							(4,316)					(4,316)	14
15	Other (specify):*			5,311									5,311	15
16	**TOTAL Health Care and Programs**	(69)		74,502				(4,316)					70,117	16
	C. General Administration													
17	Administrative			116,778		70,294	(205,224)						(18,152)	17
18	Directors Fees													18
19	Professional Services	(55,304)	15,313	(229,017)	479	(69,095)							(337,624)	19
20	Fees, Subscriptions & Promotions	(80,118)		4,148	12								(75,958)	20
21	Clerical & General Office Expenses	(862,595)	1,925	117,168	42	40	223						(743,197)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			159									159	24
25	Other Admin. Staff Transportation			990		2,911							3,901	25
26	Insurance-Prop.Liab.Malpractice		9,084	446	258								9,788	26
27	Other (specify):*			44,116			2,539						46,655	27
28	**TOTAL General Administration**	(998,017)	26,322	54,788	791	4,150	(202,462)						(1,114,428)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,046,299)	36,444	137,322	1,582	4,150	(202,462)	(4,316)					(1,073,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center **#** 0029660 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	77,996	121,554	6,231	2,576								208,357	30
31	Amortization of Pre-Op. & Org.	(2,396)	2,396											31
32	Interest	(37,890)	144,423	130	5,179								111,842	32
33	Real Estate Taxes	349	117,216		4,198								121,763	33
34	Rent-Facility & Grounds		(582,436)	18,492	(18,492)								(582,436)	34
35	Rent-Equipment & Vehicles			434									434	35
36	Other (specify):*		26,298										26,298	36
37	TOTAL Ownership	38,059	(170,549)	25,287	(6,539)								(113,742)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(30,792)											(30,792)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(73,007)											(73,007)	43
44	TOTAL Special Cost Centers	(103,799)											(103,799)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,112,039)	(134,105)	162,609	(4,957)	4,150	(202,462)	(4,316)					(1,291,120)	45

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 582,436	Mayfield Building Limited Partnership	100.00%	$	$ (582,436)	1
2	V	32	Interest Income	214	Mayfield Building Limited Partnership	100.00%		(214)	2
3	V	21	Bank Charges		Mayfield Building Limited Partnership	100.00%	275	275	3
4	V	19	Professional & Accounting Fees		Mayfield Building Limited Partnership	100.00%	15,313	15,313	4
5	V	32	Interest Expense - Greystone		Mayfield Building Limited Partnership	100.00%	144,637	144,637	5
6	V	26	Insurance		Mayfield Building Limited Partnership	100.00%	9,084	9,084	6
7	V	21	Annual Report		Mayfield Building Limited Partnership	100.00%	150	150	7
8	V	06	Repairs and Maintenance		Mayfield Building Limited Partnership	100.00%	10,122	10,122	8
9	V	30	Depreciation Expense		Mayfield Building Limited Partnership	100.00%	121,554	121,554	9
10	V	33	Real Estate Taxes		Mayfield Building Limited Partnership	100.00%	117,216	117,216	10
11	V	36	FHA Mortgage Insurance		Mayfield Building Limited Partnership	100.00%	26,298	26,298	11
12	V	31	Amortization		Mayfield Building Limited Partnership	100.00%	2,396	2,396	12
13	V	21	Entity Expense		Mayfield Building Limited Partnership	100.00%	1,500	1,500	13
14	Total			$ 582,650			$ 448,545	$ * (134,105)	14

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 81	$ 81	15
16	V	3	HOUSEKEEPING		MANAGCARE, INC.	100.00%	1,369	1,369	16
17	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,450	1,450	17
18	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,132	5,132	18
19	V	9	MEDICAL DIRECTOR		MANAGCARE, INC.	100.00%	7,908	7,908	19
20	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	55,898	55,898	20
21	V	11	ACTIVITIES		MANAGCARE, INC.	100.00%	15	15	21
22	V	12	SOCIAL SERVICE SALARIES		MANAGCARE, INC.	100.00%	5,370	5,370	22
23	V	15	NURSING EMP BENS & PR TAXES		MANAGCARE, INC.	100.00%	5,311	5,311	23
24	V	17	ADMINISTRATIVE SALARIES		MANAGCARE, INC.	100.00%	116,778	116,778	24
25	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	4,983	4,983	25
26	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	4,148	4,148	26
27	V	21	CLERICAL AND GENERAL SALARIES		MANAGCARE, INC.	100.00%	109,228	109,228	27
28	V	21	CLERICAL AND GENERAL EXP		MANAGCARE, INC.	100.00%	7,940	7,940	28
29	V	24	SEMINARS		MANAGCARE, INC.	100.00%	159	159	29
30	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	990	990	30
31	V	26	INSURANCE		MANAGCARE, INC.	100.00%	446	446	31
32	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	44,116	44,116	32
33	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	6,231	6,231	33
34	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	130	130	34
35	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	18,492	18,492	35
36	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	434	434	36
37	V	19	BOOKKEEPING	196,560	MANAGCARE, INC.	100.00%		(196,560)	37
38	V	19	ADMINISTRATIVE CONSULTANT	37,440	MANAGCARE, INC.	100.00%		(37,440)	38
39	Total			$ 234,000			$ 396,609	$ * 162,609	39

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 571	$ 571	15
16	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	220	220	16
17	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	479	479	17
18	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	12	12	18
19	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	42	42	19
20	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	258	258	20
21	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,576	2,576	21
22	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,179	5,179	22
23	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	4,198	4,198	23
24	V								24
25	V	34	RENT	18,492	4600 TOUHY, LLC	100.00%		(18,492)	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			$ 18,492			$ 13,535	$ * (4,957)	39

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 21,629	$ 21,629	15
16	V	17	ADMINISTRATIVE SALARY - JOSH DAVIS		TETRAD MANAGEMENT, LLC	100.00%	21,629	21,629	16
17	V	17	ADMINISTRATIVE SALARY - MOSHE DAVIS		TETRAD MANAGEMENT, LLC	100.00%	21,629	21,629	17
18	V	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	324	324	18
19	V	21	OFFICE EXPENSE		TETRAD MANAGEMENT, LLC	100.00%	40	40	19
20	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2,911	2,911	20
21	V	17	ADMINISTRATIVE SALARY - ELI DAVIS		TETRAD MANAGEMENT, LLC	100.00%	5,407	5,407	21
22	V								22
23	V	19	ADMINISTRATIVE CONSULTANT	69,419	TETRAD MANAGEMENT, LLC	100.00%		(69,419)	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			$ 69,419			$ 73,569	$ * 4,150	39

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 6,956	$ 6,956	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	18,364	18,364	16
17	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	223	223	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	2,539	2,539	18
19	V								19
20	V								20
21	V	17	MANAGEMENT FEES	230,544	INTERCARE, LTD. C/O MANAGCARE	100.00%		(230,544)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 230,544			$ 28,082	$ * (202,462)	39

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	14	AMBULANCE	$ 18,590	LIFELINE AMBULANCE	100.00%	$ 14,274	$ (4,316)	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			$ 18,590			$ 14,274	$ * (4,316)	39

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	.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	.06%	CAPITOL HEALTHCARE & REHABILITATION CTR., LLC	SPRINGFIELD	4600 TOUHY, LLC	LINCOLNWOOD	BUILDING CO.	4
5	ELIYAHU DAVIS	.56%	COLONIAL HEALTHCARE & REHABILITATION CTR., LLC	PRINCETON	TETRAD MANAGEMENT, LLC	LINCOLNWOOD	MANAGEMENT CO.	5
6	MOSHE DAVIS	.56%	THE HEIGHTS HEALTHCARE & REHABILITATION CTR, LLC	PEORIA HEIGHTS	LIFELINE AMBULANCE	CHICAGO	AMBULANCE SERVICES	6
7	NESANEL DAVIS	.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	.56%	RIVERSHORES NURSING & REHABILITATION CENTER, LLC	MARSEILLES				9
10	YEHOSHUA DAVIS	.56%						10
11	YISROEL DAVIS	.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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Relative	Mgmt / Admin	0%	See Attached	1.95	6.50%	Alloc. Salary	$ 6,956	17-7	1
2	Moshe Davis	Shareholder	Mgmt / Admin	.56%	See Attached	4.76	10.82%	Alloc. Fees	21,629	17-7	2
3	Yehoshua Davis	Shareholder	Administrative	.56%	See Attached	5.19	10.81%	Alloc. Fees	21,629	17-7	3
4	Nesanel Davis	Shareholder	Administrative	.56%	See Attached	5.19	10.81%	Alloc. Fees	21,629	17-7	4
5	Eli Davis	Shareholder	Administrative	.56%	See Attached	4.33	10.83%	Alloc. Fees	23,772	17-7	5
6	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	4.54	10.81%	Alloc. Salary	5,978	17-7	6
7	Moshe Wolf	Shareholder	Administrative	1.57%	See Attached	5.19	10.81%	Alloc. Salary	10,731	17-7	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	$ 112,324		13

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 748	$	52,696	$ 81	1
2	3	HOUSEKEEPING	PATIENT DAYS	487,280	10	12,659		52,696	1,369	2
3	5	UTILITIES	PATIENT DAYS	487,280	10	13,409		52,696	1,450	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	487,280	10	47,454		52,696	5,132	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	487,280	10	73,125		52,696	7,908	5
6	10	NURSING SALARIES	PATIENT DAYS	487,280	10	516,890	516,890	52,696	55,898	6
7	11	ACTIVITIES	PATIENT DAYS	487,280	10	136		52,696	15	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	487,280	10	49,654	49,654	52,696	5,370	8
9	15	NURSING EMP BENS & PR TA	PATIENT DAYS	487,280	10	49,107		52,696	5,311	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	487,280	10	1,079,846	1,079,846	52,696	116,778	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	46,077		52,696	4,983	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	487,280	10	38,354		52,696	4,148	12
13	21	CLERICAL AND GENERAL SA	PATIENT DAYS	487,280	10	1,010,032	1,010,032	52,696	109,228	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	487,280	10	73,419		52,696	7,940	14
15	24	SEMINARS	PATIENT DAYS	487,280	10	1,473		52,696	159	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	487,280	10	9,155		52,696	990	16
17	26	INSURANCE	PATIENT DAYS	487,280	10	4,123		52,696	446	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	487,280	10	407,944		52,696	44,116	18
19	30	DEPRECIATION	PATIENT DAYS	487,280	10	57,614		52,696	6,231	19
20	32	INTEREST EXPENSE	PATIENT DAYS	487,280	10	1,200		52,696	130	20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	487,280	10	171,000		52,696	18,492	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	487,280	10	4,015		52,696	434	22
23										23
24										24
25	TOTALS					$ 3,667,434	$ 2,656,422		$ 396,609	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 5,277	$	52,696	$ 571	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	487,280	10	2,035		52,696	220	2
3	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	487,280	10	4,429		52,696	479	3
4	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	487,280	10	148		52,696	12	4
5	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	487,280	10	391		52,696	42	5
6	26	INSURANCE	MNGCR. PATIENT DAYS	487,280	10	2,388		52,696	258	6
7	30	DEPRECIATION	MNGCR. PATIENT DAYS	487,280	10	23,819		52,696	2,576	7
8	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	487,280	10	47,891		52,696	5,179	8
9	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	487,280	10	38,818		52,696	4,198	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					$ 125,196	$		$ 13,535	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	487,280	10	$ 200,000	$ 200,000	52,696	$ 21,629	1
2	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	52,696	21,629	2
3	17	ADMINISTRATIVE SALARY -	PATIENT DAYS	487,280	10	200,000	200,000	52,696	21,629	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	487,280	10	3,000		52,696	324	4
5	21	OFFICE EXPENSE	PATIENT DAYS	487,280	10	374		52,696	40	5
6	25	TRAVEL	PATIENT DAYS	487,280	10	26,914		52,696	2,911	6
7	17	ADMINISTRATIVE SALARY - I	PATIENT DAYS	487,280	10	50,000	50,000	52,696	5,407	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					$ 680,288	$ 650,000		$ 73,569	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	189,385	3	$ 25,000	$ 25,000	52,696	$ 6,956	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	189,385	3	66,000		52,696	18,364	2
3	21	CLERICAL & GENERAL	AVG. HOURS WORKED	189,385	3	801		52,696	223	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	189,385	3	9,127		52,696	2,539	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					$ 100,928	$ 25,000		$ 28,082	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	14	AMBULANCE	DIRECT COST			$	$		$ 14,274	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					$	$		$ 14,274	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Greystone		X	Mortgage			$	$ 5,215,258			$ 144,637	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				1,613,835			45,805	6
7	Allocated from Managcare, Inc		X								130	7
8	See Supplemental Schedule										5,179	8
9	TOTAL Facility Related						$	$ 6,829,093			$ 195,751	9
	B. Non-Facility Related*											
10	Interest Income - Building Co.		X								(213)	10
11	Interest Income		X								(473)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (686)	14
15	TOTALS (line 9+line14)						$	$ 6,829,093			$ 195,064	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,298 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.)

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

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, LLC		X				$	$			$ 5,179	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										5,179	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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	161,900	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.)	$	165,792	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,892	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	165,700	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.)**	$	24,818	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** $ 73,799 **For** 2009 & 2010 & 2011 **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.	$	194,409	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	124,892	8
	2010	130,330	9
	2011	129,788	10
	2012	159,436	11
	2013	161,594	12

2014 Accrual = $161,250 x 1.02 = $165,700 (Rounded)

Allocated from 4600 Touhy, LLC - $4,198

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 36,284.21	$ 36,284.21
2.	16-08-419-004-0000	Long Term Care Property	$ 54,324.72	$ 54,324.72
3.	16-08-419-005-0000	Long Term Care Property	$ 37,487.25	$ 37,487.25
4.	16-08-419-006-0000	Long Term Care Property	$ 25,940.08	$ 25,940.08
5.	16-08-419-007-0000	Long Term Care Property	$ 6,793.54	$ 6,793.54
6.	16-08-419-002-0000	Long Term Care Property	$ 763.89	$ 763.89
7.	See Attached	Allocated From 4600 Touhy, LLC	$ 84,567.54	$ 4,572.70
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 246,161.23	$ 166,166.39

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT 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: 01/01/14 Ending: 12/31/14

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	Alloc 4600 Touhy			9,733	2
3	TOTALS			$ 178,724	3

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 121,554	35	$ 79,782	$ (41,772)	$ 1,070,534	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	10,804	11
12	Various			1988	38,957		20	1,257	1,257	33,410	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	1,067	1,067	39,563	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			6,071	17
18	Various			1994	24,281		20	916	916	24,258	18
19	Various			1995	1,467		20	73	73	1,424	19
20	Various			1996	64,140		20	3,092	3,092	59,349	20
21	Various			1997	15,923		20	796	796	13,977	21
22	Various			1998	966,314		20	48,316	48,316	781,189	22
23	Various			1999	137,374		20	6,869	6,869	107,470	23
24	Various			2000	43,701		20	1,358	1,358	36,436	24
25	Various			2001	9,572		20	242	242	8,000	25
26	Various			2002	14,269		20			14,269	26
27	Various			2003	3,119		20	107	107	2,213	27
28	Various			2004	32,093		20	1,687	1,687	22,989	28
29	Various			2005	14,586		20	319	319	11,349	29
30	Various			2006	8,163		20	605	605	6,392	30
31	Various			2007	97,856		20	9,786	9,786	71,245	31
32	Various			2008	188,896		20	18,615	18,615	114,491	32
33	Various			2009	32,161		20	5,077	5,077	26,314	33
34	Various			2010	97,676		20	5,528	5,528	23,170	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)		114,604	3,652		4,805	1,153	14,481	68
69	Financial Statement Depreciation			52,560			(52,560)		69
70	TOTAL (lines 4 thru 69)		$ 3,688,296	$ 177,766		$ 190,687	$ 12,921	$ 2,628,415	70

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

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		$ 3,688,296	$ 177,766		$ 190,687	$ 12,921	$ 2,628,415	1
2	Wall-Mounted Sign	2011	8,311		20	831	831	2,770	2
3	East And West Passenger Elevator	2011	78,711		20	3,936	3,936	12,463	3
4	Copper Piping	2011	5,200		20	520	520	1,863	4
5	Awning	2012	3,000		20	300	300	800	5
6	Lighting For Awning & Patio	2012	2,750		20	183	183	535	6
7	Wanderguard Alert System	2012	5,296		20	1,059	1,059	3,001	7
8	Welding Of 1/2" Square Bars Between Existing Pickets At Two Int	2012	4,500		20	450	450	1,275	8
9	Flooring In Kitchen, Dish Room, Office, And Halls	2012	15,800		20	1,580	1,580	3,358	9
10	Piping & Valves	2012	3,250		20	325	325	677	10
11	4Th Floor - 1 Resident Bathroom Flooring	2012	3,262		20	163	163	163	11
12	4Th Floor- 11 Resident Rooms - Installed New Flooring, Vanity Lig	2012	30,430		20	1,521	1,521	1,521	12
13	Chiller	2012	10,950		20	913	913	2,433	13
14	4Th Floor Bathrooms - 11 Floating Vanities With Granite Counter	2012	8,255		20	413	413	413	14
15	Walk-In Cooler & Freezer-Installed New Condensing Unit, Line V	2013	4,300		20	614	614	1,024	15
16	Asphalt Area Around Sewer	2013	5,675		20	568	568	851	16
17	Installed New Cast Iron Pipe With New Pvc Pipe & Fittings, Repla	2013	4,750		20	475	475	633	17
18	Installed Wires On 2Nd, 3Rd, And 4Th Floor And Electrical Outle	2014	8,285		20	552	552	552	18
19	Flooring, Wallcovering-Lobby, 1St Floor Corridor, Dining Room,	2014	97,365		20	4,868	4,868	4,868	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)		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	34

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

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		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	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)		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	34

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

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		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	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)		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	34

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

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		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	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)		$ 3,988,386	$ 177,766		$ 209,958	$ 32,192	$ 2,667,616	34

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

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

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 12F, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	34

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

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4	Allocated from 4600 Touhy, LLC	2012	55,527	1,424	30	1,851	427	5,553	4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10	Allocated from Managcare, Inc	2013	932	248	20	47	(201)	93	10
11	Allocated from Managcare, Inc	2012	11,593	829	20	580	(249)	1,739	11
12									12
13									13
14	Allocated from 4600 Touhy, LLC	2012	35,759	926	20	1,788	862	5,364	14
15	Allocated from 4600 Touhy, LLC	2013	8,701	204	20	435	231	870	15
16	Allocated from 4600 Touhy, LLC	2014	864	21	20	43	22	43	16
17									17
18	Allocated from Inter Care, LTD	2001	1,228		20	61	61	819	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)		$ 114,604	$ 3,652		$ 4,805	$ 1,153	$ 14,481	34

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

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 12H, Carried Forward		$ 114,604	$ 3,652		$ 4,805	$ 1,153	$ 14,481	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
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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)		$ 114,604	$ 3,652		$ 4,805	$ 1,153	$ 14,481	34

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

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	$ 484,520	$ 4,521	$ 37,007	$ 32,486	10	$ 350,602	71
72	Current Year Purchases	118,030		12,468	12,468	10	12,468	72
73	Fully Depreciated Assets	733,527				10	733,527	73
74								74
75	TOTALS	$ 1,336,077	$ 4,521	$ 49,475	$ 44,954		$ 1,096,597	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, Inc	2013	$ 13,070	$ 633	$ 1,483	$ 850	5	$ 11,951	76
77										77
78										78
79										79
80	TOTALS			$ 13,070	$ 633	$ 1,483	$ 850		$ 11,951	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)	$ 5,516,257	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,920	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 260,916	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 77,996	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,776,164	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 434 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$		$ 409,285	$		$ 409,285	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			211,677			211,677	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			448,559			448,559	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				134,482		134,482	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					81,197	13,324		94,521	13
14	TOTAL			$		$ 1,150,718	$ 147,806		$ 1,298,524	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.

STATE OF ILLINOIS

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 79,041	$ 81,245	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,252,770	3,252,770	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,874	158,986	6
7	Other Prepaid Expenses	24,730	24,730	7
8	Accounts Receivable (owners or related parties)	333,536	333,536	8
9	Other(specify):	52,820	274,390	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,870,771	$ 4,125,657	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	223,126	1,850,056	15
16	Equipment, at Historical Cost	338,797	1,617,743	16
17	Accumulated Depreciation (book methods)	(290,786)	(2,962,154)	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):		1,214,918	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 271,137	$ 3,590,202	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,141,908	$ 7,715,859	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,537,780	$ 1,548,073	26
27	Officer's Accounts Payable	600,000	600,000	27
28	Accounts Payable-Patient Deposits	36,016	36,016	28
29	Short-Term Notes Payable	1,613,835	1,613,835	29
30	Accrued Salaries Payable	187,386	187,386	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,994	20,994	31
32	Accrued Real Estate Taxes(Sch.IX-B)		165,700	32
33	Accrued Interest Payable	8,264	20,216	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,645,604	1,645,604	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,649,879	$ 5,837,824	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,215,258	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)**	$	$ 5,215,258	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,649,879	$ 11,053,082	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,507,971)	$ (3,337,223)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,141,908	$ 7,715,859	48

*(See instructions.)

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,091,869)	1	
2	Restatements (describe):		2	
3	**Rounding**	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,091,867)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(416,104)	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)**	$ (416,104)	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)**	$ (1,507,971)	24	*

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 11,019,448	1
2	Discounts and Allowances for all Levels	(2,774,743)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,244,705	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,546,248	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,546,248	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	132,216	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,531	19
20	Radiology and X-Ray	3,155	20
21	Other Medical Services	28,314	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 180,216	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,159	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,159	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	73,515	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 73,515	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,049,843	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,686,760	31
32	Health Care	4,004,790	32
33	General Administration	3,261,845	33
	B. Capital Expense		
34	Ownership	766,048	34
	C. Ancillary Expense		
35	Special Cost Centers	1,371,531	35
36	Provider Participation Fee	374,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,465,947	40
41	**Income before Income Taxes (line 30 minus line 40)****	(416,104)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (416,104)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,753,028	44
45	Private Pay - Net Inpatient Revenue	63,945	45
46	Medicare - Net Inpatient Revenue	1,232,951	46
47	Other-(specify) Hospice	99,186	47
48	Other-(specify) Insurance	95,595	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,244,705	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.**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,912	2,115	$ 91,449	$ 43.24	1
2	Assistant Director of Nursing	1,864	2,072	75,919	36.64	2
3	Registered Nurses	15,267	16,616	506,390	30.48	3
4	Licensed Practical Nurses	47,053	50,733	1,381,864	27.24	4
5	CNAs & Orderlies	92,730	102,042	1,096,098	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,558	9,452	127,497	13.49	8
9	Activity Director	1,872	2,130	33,291	15.63	9
10	Activity Assistants	10,980	12,191	116,388	9.55	10
11	Social Service Workers	8,341	9,128	146,432	16.04	11
12	Dietician					12
13	Food Service Supervisor	3,671	4,127	84,654	20.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,290	20,971	204,204	9.74	15
16	Dishwashers					16
17	Maintenance Workers	7,189	7,812	105,339	13.48	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,976	2,080	108,764	52.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,881	14,011	288,953	20.62	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	2,557	2,848	38,515	13.52	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,472	1,590	43,328	27.25	33
34	TOTAL (lines 1 - 33)	237,613	259,918	$ 4,449,085 *	$ 17.12	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	$ 16,325	01-03	35
36	Medical Director	Monthly	77,685	09-03	36
37	Medical Records Consultant	Quarterly	1,568	10-03	37
38	Nurse Consultant	Monthly	38,190	10-03	38
39	Pharmacist Consultant	Monthly	24,183	10-03	39
40	Physical Therapy Consultant	1	49	10a-03	40
41	Occupational Therapy Consultant	Visit	772	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	7,132	11-03	44
45	Social Service Consultant	Monthly	9,400	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	18,720	10-03	47
48					48
49	TOTAL (lines 35 - 48)	51	$ 194,024		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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Pfeiffer	Administrator	0	$ 108,764
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,764

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 24,740
Personnel Planners	Unemployment Consulting	12,836
Managcare, Inc.	Bookkeeping	196,560
Legal	See Attached	137,208
Tetrad Management	Administrative Consultant	69,419
Managcare, Inc.	Administrative Consultant	37,440
Achieve Accreditation	Accreditation Services	20,321
ProvINET Solutions	IT Consulting	2,640
Onwards Consulting	IT Consulting	7,576
Management and Network Srv	Care Coordination Software	500
Prospect Resources	Natural Gas Procurement	600
See Supplemental Schedule		55,528
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 565,368

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,741
Unemployment Compensation Insurance	168,508
FICA Taxes	340,355
Employee Health Insurance	41,222
Employee Meals	46,227
Illinois Municipal Retirement Fund (IMRF)*	
Health and Welfare	128,065
Dental Insurance	359
Employee Life Insurance	599
Other Employee Benefits	9,530
Pension / Union	27,537
Safe Harbor Match Expense	15,863
See Supplemental Schedule	8,473
TOTAL (agree to Schedule V, line 22, col.8)	$ 867,481

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	$ 1,990
Advertising: Employee Recruitment	12,825
Health Care Worker Background Check	2,418
(Indicate # of checks performed 78)	
Patient Background Checks 141	1,546
Dues and Subscriptions	15,676
Licenses and Permits	1,729
Allocated from Managcare, Inc	4,148
Allocated from 4600 Touhy, LLC	12
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,622
Allocated from Managcare, Inc	159
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,781

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 $22,990**

(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. $ **37,741** 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. $ **374,973**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **46,227** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.