		FOR BHF USE				

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE

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

I. IDPH License ID Number: 0029660

Facility Name: Mayfield Care Center

Address: 5905 W. Washington Blvd. (Number) Chicago (City) 60644 (Zip Code)

County: Cook

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

HFS ID Number:

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) 282-6300
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 01/01/15 to 12/31/15 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)	
	(Firm Name & Address)	Marcum, LLP 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
	(Telephone)	(847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	45,050	363	6,511	51,924	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,050	363	6,511	51,924	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.19%

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 3,662

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	339,779	87,218	15,078	442,075		442,075	62	442,137			1
2	Food Purchase		267,857		267,857	(44,056)	223,802	(1,667)	222,135			2
3	Housekeeping		13,997	320,783	334,780		334,780	1,212	335,992			3
4	Laundry		18,719	213,855	232,574		232,574		232,574			4
5	Heat and Other Utilities			156,562	156,562		156,562	(5,299)	151,263			5
6	Maintenance	70,622	22,250	114,901	207,773		207,773	22,504	230,277			6
7	Other (specify):*											7
8	**TOTAL General Services**	410,401	410,041	821,179	1,641,621	(44,056)	1,597,566	16,813	1,614,378			8
	B. Health Care and Programs											
9	Medical Director			57,060	57,060		57,060	332	57,392			9
10	Nursing and Medical Records	2,967,779	159,687	70,557	3,198,023		3,198,023	34,346	3,232,369			10
10a	Therapy	106,928		650	107,578		107,578	5,677	113,255			10a
11	Activities	141,663	16,804	1,920	160,387		160,387	10	160,397			11
12	Social Services	149,803		9,620	159,423		159,423	5,953	165,376			12
13	CNA Training											13
14	Program Transportation			23,890	23,890		23,890	(263)	23,627			14
15	Other (specify):*							9,674	9,674			15
16	**TOTAL Health Care and Programs**	3,366,173	176,491	163,697	3,706,361		3,706,361	55,729	3,762,090			16
	C. General Administration											
17	Administrative	105,359		230,544	335,903		335,903	(174,454)	161,449			17
18	Directors Fees											18
19	Professional Services			683,562	683,562	(14,880)	668,682	(395,529)	273,153			19
20	Dues, Fees, Subscriptions & Promotions			142,764	142,764		142,764	(84,685)	58,079			20
21	Clerical & General Office Expenses	330,150	25,168	942,502	1,297,820		1,297,820	(696,847)	600,973			21
22	Employee Benefits & Payroll Taxes			753,955	753,955	44,056	798,011		798,011			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,139	3,139		3,139	59	3,198			24
25	Other Admin. Staff Transportation			7,647	7,647		7,647	3,259	10,906			25
26	Insurance-Prop.Liab.Malpractice			271,144	271,144		271,144	10,046	281,190			26
27	Other (specify):*							59,760	59,760			27
28	**TOTAL General Administration**	435,509	25,168	3,035,257	3,495,934	29,175	3,525,109	(1,278,391)	2,246,718			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,212,083	611,700	4,020,133	8,843,916	(14,880)	8,829,036	(1,205,849)	7,623,187			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: 01/01/15 Ending: 12/31/15

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			66,427	66,427		66,427	204,144	270,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,250	105,250		105,250	98,051	203,301			32
33	Real Estate Taxes			36,364	36,364	14,880	51,244	136,479	187,723			33
34	Rent-Facility & Grounds			513,993	513,993		513,993	(511,926)	2,067			34
35	Rent-Equipment & Vehicles							725	725			35
36	Other (specify):*							25,808	25,808			36
37	TOTAL Ownership			722,034	722,034	14,880	736,914	(46,720)	690,194			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,010	898,212	1,076,222		1,076,222		1,076,222			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			369,753	369,753		369,753		369,753			42
43	Other (specify):*	23,142		29,580	52,722		52,722	(52,722)	0			43
44	TOTAL Special Cost Centers	23,142	178,010	1,297,545	1,498,697		1,498,697	(52,722)	1,445,975			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,235,225	789,710	6,039,712	11,064,647	(0)	11,064,647	(1,305,291)	9,759,356			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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: 01/01/15 Ending: 12/31/15

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	(7,809)	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	69,722	30		9
10	Interest and Other Investment Income	(551)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(19)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(55,810)	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	(828,902)	21		24
25	Fund Raising, Advertising and Promotional	(34,020)	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	(188,033)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,045,421)		$	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)	(259,870)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (259,870)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,305,291)		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

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Interest Expense	$ (48,250)	32	1
2	Vending Income	(1,648)	02	2
3	Marketing Consultant	(29,580)	43	3
4	Bank Charges	(6,182)	21	4
5	Marketing Salaries	(23,142)	43	5
6	Theft and Loss	(2,345)	21	6
7	Sequestration	(42,066)	21	7
8	Building Company - Bank Charges	(996)	21	8
9	Building Company - Professional/Accounting Fees	(12,200)	19	9
10	Building Company - Amortization Expense	(2,396)	31	10
11	Additional R&M	3,492	06	11
12	Prior Period Expense - A&G	(4,050)	21	12
13	Non-Allowable Legal	(9,405)	19	13
14	PPA - Medical Supply	(9,232)	10	14
15	Real Estate Taxes	(34)	33	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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**	(188,033)		49

STATE OF ILLINOIS

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			62									62	1
2	Food Purchase	(1,667)											(1,667)	2
3	Housekeeping			1,201	11								1,212	3
4	Laundry													4
5	Heat and Other Utilities	(7,809)		2,133	377								(5,299)	5
6	Maintenance	3,492	5,510	12,536	548				418				22,504	6
7	Other (specify):*													7
8	**TOTAL General Services**	(5,984)	5,510	15,932	936				418				16,813	8
	B. Health Care and Programs													
9	Medical Director			332									332	9
10	Nursing and Medical Records	(9,232)		43,578									34,346	10
10a	Therapy						5,677						5,677	10a
11	Activities			10									10	11
12	Social Services			5,953									5,953	12
13	CNA Training													13
14	Program Transportation							(263)					(263)	14
15	Other (specify):*			9,674									9,674	15
16	**TOTAL Health Care and Programs**	(9,232)		59,547			5,677	(263)					55,729	16
	C. General Administration													
17	Administrative			29,495			(203,949)						(174,454)	17
18	Directors Fees													18
19	Professional Services	(21,605)	27,080	(215,116)	132	(78,159)			(107,861)				(395,529)	19
20	Fees, Subscriptions & Promotions	(89,830)		5,138	7								(84,685)	20
21	Clerical & General Office Expenses	(884,540)	996	149,252	74				37,372				(696,847)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			59									59	24
25	Other Admin. Staff Transportation			455		2,804							3,259	25
26	Insurance-Prop.Liab.Malpractice		9,380	419	247								10,046	26
27	Other (specify):*			54,883			558		4,319				59,760	27
28	**TOTAL General Administration**	(995,975)	37,456	24,584	459	(75,354)	(203,391)		(66,170)				(1,278,391)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,011,191)	42,966	100,063	1,395	(75,354)	(197,714)	(263)	(65,751)				(1,205,849)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	69,722	124,673	7,238	2,511								204,144	30
31	Amortization of Pre-Op. & Org.	(2,396)	2,396											31
32	Interest	(48,801)	141,846		5,005								98,051	32
33	Real Estate Taxes	(34)	131,819		4,694								136,479	33
34	Rent-Facility & Grounds		(513,993)	10,632	(10,632)				2,067				(511,926)	34
35	Rent-Equipment & Vehicles			725									725	35
36	Other (specify):*		25,808										25,808	36
37	**TOTAL Ownership**	18,492	(87,451)	18,595	1,577				2,067				(46,720)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(52,722)											(52,722)	43
44	**TOTAL Special Cost Centers**	(52,722)											(52,722)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,045,421)	(44,485)	118,659	2,972	(75,354)	(197,714)	(263)	(63,684)				(1,305,291)	45

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 513,993	Mayfield Building Limited Partnership	100.00%	$	$ (513,993)	1
2	V	32	Interest Income	108	Mayfield Building Limited Partnership	100.00%		(108)	2
3	V	21	Bank Charges		Mayfield Building Limited Partnership	100.00%	996	996	3
4	V	19	Professional & Accounting Fees		Mayfield Building Limited Partnership	100.00%	12,200	12,200	4
5	V	32	Interest Expense - Greystone		Mayfield Building Limited Partnership	100.00%	141,954	141,954	5
6	V	26	Insurance		Mayfield Building Limited Partnership	100.00%	9,380	9,380	6
7	V	36	MIP Insurance Expense		Mayfield Building Limited Partnership	100.00%	25,808	25,808	7
8	V	06	Repairs and Maintenance		Mayfield Building Limited Partnership	100.00%	5,510	5,510	8
9	V	30	Depreciation Expense		Mayfield Building Limited Partnership	100.00%	124,673	124,673	9
10	V	33	Real Estate Taxes		Mayfield Building Limited Partnership	100.00%	131,819	131,819	10
11	V	31	Amortization		Mayfield Building Limited Partnership	100.00%	2,396	2,396	11
12	V	19	Real Estate Tax Protest Fees		Mayfield Building Limited Partnership	100.00%	12,130	12,130	12
13	V	19	Re Tax Appraisal Fees		Mayfield Building Limited Partnership	100.00%	2,750	2,750	13
14	Total			$ 514,101			$ 469,616	$ * (44,485)	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: 01/01/15 Ending: 12/31/15

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	$	MOSAIC HEALTHCARE	100.00%	$ 62	$ 62	15
16	V	3	HOUSEKEEPING		MOSAIC HEALTHCARE	100.00%	1,201	1,201	16
17	V	5	UTILITIES		MOSAIC HEALTHCARE	100.00%	2,133	2,133	17
18	V	6	REPAIRS AND MAINT.		MOSAIC HEALTHCARE	100.00%	12,536	12,536	18
19	V	9	MEDICAL DIRECTOR		MOSAIC HEALTHCARE	100.00%	332	332	19
20	V	10	NURSING SALARIES		MOSAIC HEALTHCARE	100.00%	62,298	62,298	20
21	V	11	ACTIVITIES		MOSAIC HEALTHCARE	100.00%	10	10	21
22	V	12	SOCIAL SERVICE SALARIES		MOSAIC HEALTHCARE	100.00%	5,953	5,953	22
23	V	15	NURSING EMP BENS & PR TAXES		MOSAIC HEALTHCARE	100.00%	9,674	9,674	23
24	V	17	ADMINISTRATIVE SALARIES		MOSAIC HEALTHCARE	100.00%	29,495	29,495	24
25	V	19	PROFESSIONAL FEES		MOSAIC HEALTHCARE	100.00%	(3,436)	(3,436)	25
26	V	20	FEES, SUBSCRIPTIONS		MOSAIC HEALTHCARE	100.00%	5,138	5,138	26
27	V	21	CLERICAL AND GENERAL SALARIES		MOSAIC HEALTHCARE	100.00%	194,061	194,061	27
28	V	21	CLERICAL AND GENERAL EXP	65,520	MOSAIC HEALTHCARE	100.00%	20,711	(44,809)	28
29	V	24	SEMINARS		MOSAIC HEALTHCARE	100.00%	59	59	29
30	V	25	ADMIN. STAFF TRANS.		MOSAIC HEALTHCARE	100.00%	455	455	30
31	V	26	INSURANCE		MOSAIC HEALTHCARE	100.00%	419	419	31
32	V	27	GEN. ADMIN. EMP. BEN.		MOSAIC HEALTHCARE	100.00%	54,883	54,883	32
33	V	30	DEPRECIATION		MOSAIC HEALTHCARE	100.00%	7,238	7,238	33
34	V	34	RENT - BUILDING (RELATED)		MOSAIC HEALTHCARE	100.00%	10,632	10,632	34
35	V	35	EQUIPMENT RENTAL		MOSAIC HEALTHCARE	100.00%	725	725	35
36	V	19	BOOKKEEPING	169,259	MOSAIC HEALTHCARE	100.00%		(169,259)	36
37	V	19	ADMINISTRATIVE CONSULTANT	42,421	MOSAIC HEALTHCARE	100.00%		(42,421)	37
38	V	10	MDS CONSULTANT	18,720	MOSAIC HEALTHCARE	100.00%		(18,720)	38
39	Total			$ 295,920			$ 414,579	$ * 118,659	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSKEEPING	$	4600 TOUHY, LLC	100.00%	$ 11	$ 11	15
16	V	5	UTILITIES		4600 TOUHY, LLC	100.00%	377	377	16
17	V	6	REPAIRS & MAINT.		4600 TOUHY, LLC	100.00%	548	548	17
18	V	19	PROFESSIONAL FEES		4600 TOUHY, LLC	100.00%	132	132	18
19	V	20	FEES, SUBSCRIPTIONS		4600 TOUHY, LLC	100.00%	7	7	19
20	V	21	CLERICAL & GENERAL		4600 TOUHY, LLC	100.00%	74	74	20
21	V	26	INSURANCE		4600 TOUHY, LLC	100.00%	247	247	21
22	V	30	DEPRECIATION		4600 TOUHY, LLC	100.00%	2,511	2,511	22
23	V	32	INTEREST EXPENSE		4600 TOUHY, LLC	100.00%	5,005	5,005	23
24	V	33	REAL ESTATE TAXES		4600 TOUHY, LLC	100.00%	4,694	4,694	24
25	V								25
26	V	34	RENT	10,632	4600 TOUHY, LLC	100.00%		(10,632)	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			$ 10,632			$ 13,605	$ * 2,972	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: 01/01/15 Ending: 12/31/15

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	19	PROFESSIONAL FEES		TETRAD MANAGEMENT, LLC	100.00%	494	$ 494	15
16	V	25	TRAVEL		TETRAD MANAGEMENT, LLC	100.00%	2,804	2,804	16
17	V								17
18	V	19	ADMINISTRATIVE CONSULTANT	78,653	TETRAD MANAGEMENT, LLC	100.00%		(78,653)	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			$ 78,653			$ 3,299	$ * (75,354)	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 6,890	$ 6,890	15
16	V	17	COMMISSIONS AND FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	19,705	19,705	16
17	V	10A	THERAPY CONSULTATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	5,677	5,677	17
18	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	558	558	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			$ 32,830	$ * (197,714)	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	AMBULANCE	$ 3,429	LIFELINE AMBULANCE	100.00%	$ 3,166	$ (263)	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			$ 3,429			$ 3,166	$ * (263)	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	LEGAL & PROFESSIONAL		PLATINUM BILLING SOLUTIONS	30.00%	2,746	$ 2,746	15
16	V	6	REPAIRS & MAINTENANCE		PLATINUM BILLING SOLUTIONS	30.00%	418	418	16
17	V	21	CLERICAL & GENERAL EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	8,198	8,198	17
18	V	21	CLERICAL & GENERAL SALARY		PLATINUM BILLING SOLUTIONS	30.00%	29,174	29,174	18
19	V	27	EMPLOYEE BENEFITS		PLATINUM BILLING SOLUTIONS	30.00%	4,319	4,319	19
20	V	34	RENT EXPENSE		PLATINUM BILLING SOLUTIONS	30.00%	2,067	2,067	20
21	V	19	PROFESSIONAL FEES	110,607	PLATINUM BILLING SOLUTIONS	30.00%		(110,607)	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			$ 110,607			$ 46,923	$ * (63,684)	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/15 Ending: 12/31/15

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/15 Ending: 12/31/15

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	MOSAIC HC	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	PLATINUM BILLING SOLUTION	LAKEWOOD	BILLING	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: 01/01/15 Ending: 12/31/15

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

STATE OF ILLINOIS

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yosef Davis	Relative	Mgmt/Admin		See Attached	1.90	6.33%	Alloc. Salary	$ 6,890	17-7	1
2	Eli Davis	Shareholder	Administrative	0.56%	See Attached	4.22	10.55%	Alloc. Fees	19,705	17-7	2
3	Ronnie O'Connell	Shareholder	Administrative	1.57%	See Attached	4.43	10.55%	Alloc. Salary	5,827	17-7	3
4	Moshe Wolf	Shareholder	Administrative	1.57%	See Attached	5.07	10.56%	Alloc. Salary	10,407	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 42,829		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

Name of Related Organization: MOSAIC HEALTHCARE
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

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

	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	491,775	10	$ 583	$	51,924	$ 62	1
2	3	HOUSEKEEPING	PATIENT DAYS	491,775	10	11,376		51,924	1,201	2
3	5	UTILITIES	PATIENT DAYS	491,775	10	20,206		51,924	2,133	3
4	6	REPAIRS AND MAINT.	PATIENT DAYS	491,775	10	118,728		51,924	12,536	4
5	9	MEDICAL DIRECTOR	PATIENT DAYS	491,775	10	3,145		51,924	332	5
6	10	NURSING SALARIES	PATIENT DAYS	491,775	10	590,024	590,024	51,924	62,298	6
7	11	ACTIVITIES	PATIENT DAYS	491,775	10	95		51,924	10	7
8	12	SOCIAL SERVICE SALARIES	PATIENT DAYS	491,775	10	56,383	56,383	51,924	5,953	8
9	15	NURSING EMP BENS & PR TAX	PATIENT DAYS	491,775	10	91,625		51,924	9,674	9
10	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	491,775	10	279,351	279,351	51,924	29,495	10
11	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	(32,545)		51,924	(3,436)	11
12	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	491,775	10	48,662		51,924	5,138	12
13	21	CLERICAL AND GENERAL SAI	PATIENT DAYS	491,775	10	1,837,959	1,837,959	51,924	194,061	13
14	21	CLERICAL AND GENERAL EX	PATIENT DAYS	491,775	10	196,155		51,924	20,711	14
15	24	SEMINARS	PATIENT DAYS	491,775	10	556		51,924	59	15
16	25	ADMIN. STAFF TRANS.	PATIENT DAYS	491,775	10	4,308		51,924	455	16
17	26	INSURANCE	PATIENT DAYS	491,775	10	3,971		51,924	419	17
18	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	491,775	10	519,798		51,924	54,883	18
19	30	DEPRECIATION	PATIENT DAYS	491,775	10	68,552		51,924	7,238	19
20	32	INTEREST EXPENSE	PATIENT DAYS	491,775	10			51,924		20
21	34	RENT - BUILDING (RELATED)	PATIENT DAYS	491,775	10	100,700		51,924	10,632	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	491,775	10	6,863		51,924	725	22
23										23
24										24
25	TOTALS					$ 3,926,495	$ 2,763,717		$ 414,579	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSKEEPING	MNGCR. PATIENT DAYS	491,775	10	$ 107	$	51,924	$ 11	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	491,775	10	3,569		51,924	377	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	491,775	10	5,190		51,924	548	3
4	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	491,775	10	1,250		51,924	132	4
5	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	491,775	10	63		51,924	7	5
6	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	491,775	10	698		51,924	74	6
7	26	INSURANCE	MNGCR. PATIENT DAYS	491,775	10	2,336		51,924	247	7
8	30	DEPRECIATION	MNGCR. PATIENT DAYS	491,775	10	23,779		51,924	2,511	8
9	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	491,775	10	47,406		51,924	5,005	9
10	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	491,775	10	44,453		51,924	4,694	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,850	$		$ 13,605	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [ ]

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

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

	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	19	PROFESSIONAL FEES	PATIENT DAYS	491,775	10	4,682		51,924	494	1
2	25	TRAVEL	PATIENT DAYS	491,775	10	26,559		51,924	2,804	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					$ 31,241	$		$ 3,299	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	188,403	3	$ 25,000	$ 25,000	51,924	$ 6,890	1
2	17	COMMISSIONS AND FEES	AVG. HOURS WORKED	188,403	3	71,500		51,924	19,705	2
3	10A	THERAPY CONSULTATION	AVG. HOURS WORKED	188,403	3	20,600		51,924	5,677	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	188,403	3	2,026		51,924	558	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					$ 119,126	$ 25,000		$ 32,830	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 3,166	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					$	$		$ 3,166	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: PLATINUM BILLING SOLUTIONS
Street Address: 1100 TOWBIN AVENUE, UNIT C
City / State / Zip Code: LAKEWOOD, NJ 08701
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	19	LEGAL & PROFESSIONAL	PATIENT DAYS	188,403	3	9,965		51,924	2,746	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	188,403	3	1,518		51,924	418	2
3	21	CLERICAL & GENERAL EXPI	PATIENT DAYS	188,403	3	29,745		51,924	8,198	3
4	21	CLERICAL & GENERAL SALA	PATIENT DAYS	188,403	3	105,856	105,856	51,924	29,174	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	188,403	3	15,673		51,924	4,319	5
6	34	RENT EXPENSE	PATIENT DAYS	188,403	3	7,500		51,924	2,067	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					$ 170,257	$ 105,856		$ 46,923	25

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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: 01/01/15 Ending: 12/31/15

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			$	$ 5,116,447			$ 141,954	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial Bank		X	Line of Credit				1,200,713			57,000	6
7	Allocated from 4600 Touhy, LLC		X								5,005	7
8												8
9	TOTAL Facility Related						$	$ 6,317,160			$ 203,960	9
	B. Non-Facility Related*											
10	Interest Income - Building Co.		X								(108)	10
11	Interest Income		X								(551)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (659)	14
15	TOTALS (line 9+line14)						$	$ 6,317,160			$ 203,301	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 25,808 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: 01/01/15 Ending: 12/31/15

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**		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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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: 01/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2014 report.	$	165,700	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.)	$	169,543	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,843	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	169,000	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.**	$	14,880	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** $ 36,364 **For** 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.	$	187,723	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2010	130,330	8
2011	129,788	9
2012	159,436	10
2013	161,594	11
2014	164,849	12

2015 Accrual = $164,849 x 1.025 = $168,970 (Rounded)

Allocated from 4600 Touhy, LLC - $4,694

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 37,015.10	$ 37,015.10
2.	16-08-419-004-0000	Long Term Care Property	$ 55,419.03	$ 55,419.03
3.	16-08-419-005-0000	Long Term Care Property	$ 38,242.44	$ 38,242.44
4.	16-08-419-006-0000	Long Term Care Property	$ 26,462.63	$ 26,462.63
5.	16-08-419-007-0000	Long Term Care Property	$ 6,930.41	$ 6,930.41
6.	16-08-419-002-0000	Long Term Care Property	$ 779.24	$ 779.24
7.	See Attached	Allocated From 4600 Touhy, LLC	$ 86,316.15	$ 4,556.84
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 251,165.00	$ 169,405.69

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2000	$ 168,991	1
2	Allocated from 4600 Touhy LLC			9,503	2
3	TOTALS			$ 178,494	3

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 124,673	35	$ 79,782	$ (44,891)	$ 1,150,316	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	11,195	11
12	Various			1988	38,957		20	1,257	1,257	34,667	12
13	Various			1989	57,789		20			57,771	13
14	Various			1990	40,078		20	356	356	39,919	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			24,258	18
19	Various			1995	1,467		20	41	41	1,465	19
20	Various			1996	64,140		20	2,978	2,978	62,327	20
21	Various			1997	15,923		20	796	796	14,773	21
22	Various			1998	966,314		20	48,316	48,316	829,505	22
23	Various			1999	130,948		20	6,547	6,547	109,018	23
24	Various			2000	43,701		20	1,358	1,358	37,794	24
25	Various			2001	9,572		20	242	242	8,242	25
26	Various			2002	14,269		20			14,269	26
27	Various			2003	3,119		20	107	107	2,320	27
28	Various			2004	32,093		20	1,687	1,687	24,676	28
29	Various			2005	14,586		20	319	319	11,668	29
30	Various			2006	8,163		20	605	605	6,996	30
31	Various			2007	97,856		20	9,786	9,786	81,030	31
32	Various			2008	168,094		20	17,575	17,575	125,738	32
33	Various			2009	32,161		20	2,012	2,012	28,326	33
34	Various			2010	97,676		20	5,528	5,528	28,698	34
35	Various			2011	92,222		20	5,287	5,287	22,383	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: 01/01/15 Ending: 12/31/15

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)		111,911	3,185		4,693	1,508	18,903	68
69	Financial Statement Depreciation			66,427			(66,427)		69
70	TOTAL (lines 4 thru 69)		$ 3,750,598	$ 194,285		$ 189,661	$ (4,624)	$ 2,823,575	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: 01/01/15 Ending: 12/31/15

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		$ 3,750,598	$ 194,285		$ 189,661	$ (4,624)	$ 2,823,575	1
2	Awning	2012	3,000		20	300	300	1,100	2
3	Lighting For Awning & Patio	2012	2,750		20	183	183	718	3
4	Wanderguard Alert System	2012	5,296		20	1,059	1,059	4,060	4
5	Welding Of 1/2" Square Bars Between Existing Pickets At Two In	2012	4,500		20	450	450	1,725	5
6	Flooring In Kitchen, Dish Room, Office, And Halls	2012	15,800		20	1,580	1,580	4,938	6
7	Piping & Valves	2012	3,250		20	325	325	1,002	7
8	4Th Floor - 1 Resident Bathroom Flooring	2012	3,262		20	163	163	557	8
9	4Th Floor - 11 Resident Room Floors, Vanity Lights, Window Tre	2012	30,430		20	1,522	1,522	5,198	9
10	4Th Floor Bathrooms - Vanities, Granite Countertops, Sink & Bac	2012	8,255		20	413	413	1,410	10
11	Chiller	2012	10,950		20	913	913	3,346	11
12	Walk-In Cooler & Freezer-Installed New Condensing Unit, Line V	2013	4,300		20	614	614	1,638	12
13	Asphalt Area Around Sewer	2013	5,675		20	568	568	1,419	13
14	Installed New Cast Iron Pipe With New Pvc Pipe & Fittings, Repla	2013	4,750		20	475	475	1,108	14
15	Install Wires On 2Nd, 3Rd, 4Th Floors & Electrical Outlets For C	2014	8,285		20	414	414	552	15
16	Floor, Wallcovering - Lobby, 1St Flr Corridor, Dining Rm, Vestib	2014	97,365		20	9,737	9,737	15,416	16
17	Relocate Network Cable & Hardware, Relocate Wireless Access Po	2015	9,498		20	316	316	316	17
18	Install Photocells On New Light Fixtures, Install 250 Metal Halide	2015	3,975		20	132	132	132	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)		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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: 01/01/15 Ending: 12/31/15

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		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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)		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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: 01/01/15 Ending: 12/31/15

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		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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)		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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: 01/01/15 Ending: 12/31/15

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		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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)		$ 3,971,939	$ 194,285		$ 208,824	$ 14,539	$ 2,868,212	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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: 01/01/15 Ending: 12/31/15

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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4	Allocated from 4600 Touhy, LLC	2012	54,213	1,390	30	1,807	417	7,228	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated from Mosaic HC	2013	910	175	20	46	(129)	137	10
11	Allocated from Mosaic HC	2012	11,319	499	20	566	67	2,264	11
12									12
13									13
14	Allocated from 4600 Touhy, LLC	2012	34,913	899	20	1,746	847	6,983	14
15	Allocated from 4600 Touhy, LLC	2013	8,495	200	20	425	225	1,274	15
16	Allocated from 4600 Touhy, LLC	2014	844	22	20	42	20	84	16
17									17
18	Allocated from Inter Care, LTD	2001	1,217		20	61	61	933	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)		$ 111,911	$ 3,185		$ 4,693	$ 1,508	$ 18,903	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: 01/01/15 Ending: 12/31/15

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		$ 111,911	$ 3,185		$ 4,693	$ 1,508	$ 18,903	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 111,911	$ 3,185		$ 4,693	$ 1,508	$ 18,903	34

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

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	$ 607,510	$ 6,209	$ 53,510	$ 47,301	10	$ 407,895	71
72	Current Year Purchases	42,211		8,238	8,238	10	8,238	72
73	Fully Depreciated Assets	735,844				10	735,844	73
74								74
75	TOTALS	$ 1,385,566	$ 6,209	$ 61,748	$ 55,539		$ 1,151,978	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 Mosaic HC	2015	$ 10,030	$ 356	$	$ (356)	5	$ 10,030	76
77										77
78										78
79										79
80	TOTALS			$ 10,030	$ 356	$	$ (356)		$ 10,030	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)	$ 5,546,029	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 200,850	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,572	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 69,722	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,030,219	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	Construction in Progress	$ 82,950	92
93			93
94			94
95		$ 82,950	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.

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	Allocated from Platinum Billing Solutions				2,067			5
6								6
7	TOTAL				$ 2,067 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 725 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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,006	$		$ 325,006	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			118,566			118,566	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			361,533			361,533	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				158,753		158,753	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					93,107	19,257		112,364	13
14	TOTAL			$		$ 898,212	$ 178,010		$ 1,076,222	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.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 3,555	$ 22,009	1
2	Cash-Patient Deposits	25,469	25,469	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,992,890	3,992,890	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,095	137,794	6
7	Other Prepaid Expenses	21,276	21,276	7
8	Accounts Receivable (owners or related parties)	152,938	152,938	8
9	Other(specify):	138,797	138,797	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,442,020	$ 4,491,173	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	227,082	1,854,012	15
16	Equipment, at Historical Cost	381,708	1,660,654	16
17	Accumulated Depreciation (book methods)	(357,213)	(3,153,254)	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):	82,950	1,324,301	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 334,527	$ 3,555,352	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,776,547	$ 8,046,525	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,773,299	$ 1,778,824	26
27	Officer's Accounts Payable	600,000	600,000	27
28	Accounts Payable-Patient Deposits	26,088	26,088	28
29	Short-Term Notes Payable	1,200,713	1,200,713	29
30	Accrued Salaries Payable	281,944	281,944	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,422	21,422	31
32	Accrued Real Estate Taxes(Sch.IX-B)		169,000	32
33	Accrued Interest Payable	3,135	14,860	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,786,901	2,538,948	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,693,502	$ 6,631,799	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,116,447	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)**	$	$ 5,116,447	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,693,502	$ 11,748,246	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,916,955)	$ (3,701,721)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,776,547	$ 8,046,525	48

*(See instructions.)

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,507,971)	1
2	Restatements (describe):		2
3	Bad Debt, Medicare Settlement Income	(87,029)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,595,000)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(321,955)	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)**	$ (321,955)	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)**	$ (1,916,955)	24 *

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 11,053,734	1
2	Discounts and Allowances for all Levels	(2,475,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 8,578,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,911,895	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 1,911,895	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	145,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,972	19
20	Radiology and X-Ray	18,430	20
21	Other Medical Services	9,649	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 214,187	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	551	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 551	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	38,012	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 38,012	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 10,742,692	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,641,621	31
32	Health Care	3,706,361	32
33	General Administration	3,495,934	33
	B. Capital Expense		
34	Ownership	722,034	34
	C. Ancillary Expense		
35	Special Cost Centers	1,128,944	35
36	Provider Participation Fee	369,753	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 11,064,647	40
41	Income before Income Taxes (line 30 minus line 40)**	(321,955)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (321,955)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,813,140	44
45	Private Pay - Net Inpatient Revenue	207,522	45
46	Medicare - Net Inpatient Revenue	1,123,329	46
47	Other-(specify) Hospice	166,935	47
48	Other-(specify) Insurance	267,121	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,578,047	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.

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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	2,000	2,080	$ 93,262	$ 44.84	1
2	Assistant Director of Nursing	1,624	1,739	68,429	39.35	2
3	Registered Nurses	14,930	15,912	493,977	31.04	3
4	Licensed Practical Nurses	40,941	44,113	1,204,762	27.31	4
5	CNAs & Orderlies	89,501	99,041	1,082,236	10.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,283	6,010	106,928	17.79	8
9	Activity Director	1,936	2,080	39,105	18.80	9
10	Activity Assistants	9,304	10,279	102,558	9.98	10
11	Social Service Workers	7,460	8,102	149,803	18.49	11
12	Dietician					12
13	Food Service Supervisor	4,551	4,856	101,330	20.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,909	21,986	238,449	10.85	15
16	Dishwashers					16
17	Maintenance Workers	3,545	3,880	70,622	18.20	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,992	2,122	105,359	49.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,921	16,256	330,150	20.31	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	1,621	1,818	25,113	13.81	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	704	720	23,142	32.14	33
34	TOTAL (lines 1 - 33)	220,222	240,994	$ 4,235,225 *	$ 17.57	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	$ 15,078	01-03	35
36	Medical Director	Monthly	57,060	09-03	36
37	Medical Records Consultant	Visit	400	10-03	37
38	Nurse Consultant	Monthly	37,440	10-03	38
39	Pharmacist Consultant	Monthly	13,997	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	9	650	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	1,920	11-03	44
45	Social Service Consultant	Monthly	9,620	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	18,720	10-03	47
48					48
49	TOTAL (lines 35 - 48)	22	$ 154,885		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Pfeiffer	Administrator	0	$ 13,455
Sherrilyn Harris	Administrator	0	21,873
Shmuel Weinberger	Administrator	0	70,032
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 105,359

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Frost/Marcum	Accounting	$ 33,955
Personnel Planners	Unemployment Consulting	13,324
See Attached	Legal	120,806
Mosaic HC	Bookkeeping	169,259
Prospect Resources	Natural Gas Procurement	700
Creative Technology	IT Consulting	29,549
Onwards Consulting	IT Consulting	2,008
Provinet Solutions	IT Consulting	859
Tetrad Management	Administrative Consultant	78,653
Mosaic HC	Administrative Consultant	42,421
Achieve Accreditation	Accreditation Services	19,247
See Supplemental Schedule		172,781
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 683,561

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,373
Unemployment Compensation Insurance	141,343
FICA Taxes	309,799
Employee Health Insurance	37,660
Employee Meals	44,056
Illinois Municipal Retirement Fund (IMRF)*	
Health and Welfare	109,009
Employee Life Insurance	765
Other Employee Benefits	19,364
Pension/Union	28,084
Safe Harbor Match Expense	4,931
Employee Disability Insurance	1,390
See Supplemental Schedule	1,238
TOTAL (agree to Schedule V, line 22, col.8)	$ 798,011

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 2,240
Advertising: Employee Recruitment		20,158
Health Care Worker Background Check		1,719
(Indicate # of checks performed 55)		
Patient Background Checks	100.2	1,099
Dues and Subscriptions		23,795
Licenses and Permits		3,922
Allocated from Mosaic		5,138
Allocated from 4600 Touhy, LLC		7
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 58,078

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,139
Allocated from Mosaic	59
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,198

**See instructions.

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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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $21,250

(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. $ 37,707 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. $ 369,753
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 44,056 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% In 14

d. Have vehicle usage logs been maintained? No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

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

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

(19) 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.