

Facility Name & ID Number MAYFIELD CARE CENTER

0029660 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 _____

	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		Skilled (SNF)			1
2	104	Skilled Pediatric (SNF/PED)	104	38,064	2
3		Intermediate (ICF)			3
4	52	Intermediate/DD	52	19,032	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	57,096	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	20,650	231	3,069	23,950	8
9	SNF/PED					9
10	ICF	23,547		6,133	29,680	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,197	231	9,202	53,630	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.93%

D. How many bed-hold days during this year were paid by Public Aid? 1,492 (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)
N/A

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/85 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 2,624

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	215,827	30,399	12,000	258,226		258,226		258,226		1
2	Food Purchase		242,000		242,000	(29,953)	212,047	(10)	212,036		2
3	Housekeeping	162,967	40,342		203,309		203,309	739	204,048		3
4	Laundry	65,483	13,027		78,510		78,510		78,510		4
5	Heat and Other Utilities			100,517	100,517		100,517	2,513	103,030		5
6	Maintenance	68,775	15,113	59,709	143,597		143,597	3,624	147,221		6
7	Other (specify):*							30	30		7
8	TOTAL General Services	513,052	340,881	172,226	1,026,159	(29,953)	996,206	6,896	1,003,101		8
9	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,573,216	126,859	6,713	1,706,788		1,706,788	(5,128)	1,701,660		10
10a	Therapy	100,096		4,325	104,421		104,421		104,421		10a
11	Activities	73,329	10,178	2,619	86,126		86,126		86,126		11
12	Social Services	63,020		3,942	66,962		66,962		66,962		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,809,661	137,037	23,599	1,970,297		1,970,297	(5,128)	1,965,169		16
17	C. General Administration										
17	Administrative	201,154		18,000	219,154		219,154	42,649	261,803		17
18	Directors Fees										18
19	Professional Services			324,729	324,729		324,729	(214,559)	110,170		19
20	Dues, Fees, Subscriptions & Promotions			36,415	36,415		36,415	(11,898)	24,517		20
21	Clerical & General Office Expenses	63,992	34,056	317,332	415,380		415,380	(160,111)	255,269		21
22	Employee Benefits & Payroll Taxes			389,861	389,861	29,953	419,814		419,814		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,615	2,615		2,615	1,498	4,113		24
25	Other Admin. Staff Transportation			1,343	1,343		1,343	153	1,496		25
26	Insurance-Prop.Liab.Malpractice			102,757	102,757		102,757	53,506	156,263		26
27	Other (specify):*							27,348	27,348		27
28	TOTAL General Administration	265,146	34,056	1,193,052	1,492,254	29,953	1,522,207	(261,414)	1,260,793		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,587,859	511,974	1,388,877	4,488,710		4,488,710	(259,646)	4,229,064		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.

MAYFIELD CARE CENTER
0029660
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>29,953</u>	
2	FOOD		<u>29,953</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u> </u>	
19	PROFESSIONAL FEES		<u> </u>

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
30	D. Ownership Depreciation			10,296	10,296		10,296	233,441	243,737		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			13,308	13,308		13,308	428,725	442,033		32
33	Real Estate Taxes			2,134	2,134		2,134	52,889	55,023		33
34	Rent-Facility & Grounds			599,834	599,834		599,834	(599,834)			34
35	Rent-Equipment & Vehicles			41,523	41,523		41,523	(15,804)	25,719		35
36	Other (specify):*										36
37	TOTAL Ownership			667,095	667,095		667,095	99,417	766,512		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		75,473	59,306	134,779		134,779		134,779		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,644	85,644		85,644		85,644		42
43	Other (specify):*	79,868		4,564	84,432		84,432	(84,432)			43
44	TOTAL Special Cost Centers	79,868	75,473	149,514	304,855		304,855	(84,432)	220,423		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,667,727	587,447	2,205,486	5,460,660		5,460,660	(244,661)	5,215,999		45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(23,658)	30		9
10	Interest and Other Investment Income	(3,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	2		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	(131)	21		18
19	Entertainment				19
20	Contributions	(12,380)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(224,030)	21		24
25	Fund Raising, Advertising and Promotional	(11,922)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,900)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(217,765)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (495,153)		\$	30

OHF 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	2	
		Amount	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)	250,492	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 250,492		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (244,661)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

MAYFIELD CARE CENTER

ID# 0029660

Report Period Beginning: 01/01/00

Ending: 12/31/00

	Amount	Sch. V Line Reference
1		6
2		43
3		43
4		10
5		35
6		21
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89		89
90		90
Total	(217,765)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAYFIELD CARE CENTER# 0029660 Report Period Beginning:

01/01/00

Ending:

12/31/00

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													1
2	Food Purchase	(10)											(10)	2
3	Housekeeping			739									739	3
4	Laundry													4
5	Heat and Other Utilities			1,191		1,322							2,513	5
6	Maintenance			2,669		955							3,624	6
7	Other (specify):*					30							30	7
8	TOTAL General Services	(10)		4,599		2,307							6,896	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,638)		(490)									(5,128)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(4,638)		(490)									(5,128)	16
	C. General Administration													
17	Administrative			51,080	(9,417)	986							42,649	17
18	Directors Fees													18
19	Professional Services	(9,110)	9,110	(214,887)	194	134							(214,559)	19
20	Fees, Subscriptions & Promotions	(12,166)		257	2	9							(11,898)	20
21	Clerical & General Office Expenses	(239,469)		79,252	4	102							(160,111)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(149)		1,647									1,498	24
25	Other Admin. Staff Transportation			153									153	25
26	Insurance-Prop.Liab.Malpractice		52,641	746		119							53,506	26
27	Other (specify):*			26,821	527								27,348	27
28	TOTAL General Administration	(260,894)	61,751	(54,931)	(8,690)	1,350							(261,414)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(265,542)	61,751	(50,822)	(8,690)	3,657							(259,646)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAYFIELD CARE CENTER# 0029660

Report Period Beginning:

01/01/00 Ending:12/31/00

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

	Capital Expense	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	D. Ownership Depreciation	(23,658)	248,592	7,118	8	1,381							233,441	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,357)	429,353	100		2,629							428,725	32
33	Real Estate Taxes		50,600			2,289							52,889	33
34	Rent-Facility & Grounds		(599,834)	9,853		(9,853)							(599,834)	34
35	Rent-Equipment & Vehicles	(16,668)		864									(15,804)	35
36	Other (specify):*	(101,496)	101,496											36
37	TOTAL Ownership	(145,179)	230,207	17,935	8	(3,554)							99,417	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):*	(84,432)											(84,432)	43
44	TOTAL Special Cost Centers	(84,432)											(84,432)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(495,153)	291,958	(32,887)	(8,682)	103							(244,661)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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)	
1	V	34 RENTAL INCOME	\$ 552,834	MAYFIELD BUILDING	100.00%	\$	\$ (552,834)	1
2	V	34 RENTAL INCOME - R/E TAXES	47,000	MAYFIELD BUILDING	100.00%		(47,000)	2
3	V	19 PROFESSIONAL FEES		MAYFIELD BUILDING	100.00%	7,168	7,168	3
4	V	32 INTEREST - GMAC		MAYFIELD BUILDING	100.00%	429,353	429,353	4
5	V	30 DEPRECIATION EXPENSE		MAYFIELD BUILDING	100.00%	248,592	248,592	5
6	V	36 AMORTIZATION OF LOAN COST		MAYFIELD BUILDING	100.00%	97,833	97,833	6
7	V	36 AMORTIZATION OF LOAN COST		MAYFIELD BUILDING	100.00%	3,663	3,663	7
8	V	33 REAL ESTATE TAXES		MAYFIELD BUILDING	100.00%	50,600	50,600	8
9	V	26 FHA MORTGAGE INSURANCE		MAYFIELD BUILDING	100.00%	52,641	52,641	9
10	V	19 ACCOUNTING FEES		MAYFIELD BUILDING	100.00%	5,130	5,130	10
11	V	19 LEGAL		MAYFIELD BUILDING	100.00%	(3,188)	(3,188)	11
12	V							12
13	V							13
14	Total		\$ 599,834			\$ 891,792	\$ * 291,958	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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 HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 739	\$	739	15
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,191		1,191	16
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,669		2,669	17
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%	(490)		(490)	18
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	53,062		53,062	19
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	393		393	20
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	257		257	21
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	79,252		79,252	22
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	1,647		1,647	23
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	153		153	24
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	746		746	25
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	26,821		26,821	26
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	7,118		7,118	27
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	100		100	28
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	9,853		9,853	29
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	864		864	30
31	V	19 HOME OFFICE	215,280	MANAGCARE, INC.	100.00%	0		(215,280)	31
32	V	17 ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	(1,148)		(1,148)	32
33	V	17 ADMIN. SALARY - AHUYA WEINREB		MANAGCARE, INC.	100.00%	(801)		(801)	33
34	V	17 ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%	(33)		(33)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 215,280			\$ 182,393	\$ *	(32,887)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	17	ADMINISTRATIVE	\$		INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 8,583	\$ 8,583	15
16	V	19	PROFESSIONAL FEES			INTERCARE, LTD. C/O MANAGCARE	100.00%	194	194	16
17	V	20	FEES, SUBSCRIPTIONS			INTERCARE, LTD. C/O MANAGCARE	100.00%	2	2	17
18	V	21	CLERICAL & GENERAL			INTERCARE, LTD. C/O MANAGCARE	100.00%	4	4	18
19	V	27	EMPLOYEE BENEFITS			INTERCARE, LTD. C/O MANAGCARE	100.00%	527	527	19
20	V	30	DEPRECIATION			INTERCARE, LTD. C/O MANAGCARE	100.00%	8	8	20
21	V									21
22	V	17	MANAGEMENT FEES	18,000		INTERCARE, LTD. C/O MANAGCARE	100.00%		(18,000)	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$ 18,000				\$ 9,318	\$ * (8,682)	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	5	UTILITIES	\$		100.00%	\$ 1,322	\$	1,322	15
16	V	6	REPAIRS & MAINT.				955		955	16
17	V	7	EMPLOYEE BEN.-R&M SAL.				30		30	17
18	V	17	ADMIN.-M. WOLF				986		986	18
19	V	19	PROFESSIONAL FEES				134		134	19
20	V	20	FEES, SUBSCRIPTIONS				9		9	20
21	V	21	CLERICAL & GENERAL				102		102	21
22	V	26	INSURANCE				119		119	22
23	V	30	DEPRECIATION				1,381		1,381	23
24	V	32	INTEREST EXPENSE				2,629		2,629	24
25	V	33	REAL ESTATE TAXES				2,289		2,289	25
26	V	34	RENT		9,853		0		(9,853)	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			\$	9,853		\$ 9,956	\$ *	103	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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		\$				\$	0 \$ *	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: 01/01/00 Ending: 12/31/00

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	YOSEF DAVIS	Shareholder	Mgmt/Admin	69.32%	SEE ATACHED	5	8.33	Alloc. Sal	\$ 8,583	17-7	1
2	YOSEF DAVIS	Shareholder	Mgmt/Admin	69.32%	SEE ATACHED	5	8.33	Salary	15,000	17-1	2
3	MOSHE DAVIS	Shareholder	Administrative	.25%	SEE ATACHED	13.2	33.00	Alloc. Sal	(1,216)	17-7	3
4	MOSHE DAVIS	Shareholder	Administrative	.25%	SEE ATACHED	13.2	33.00	Salary	41,692	17-1	4
5	JOSHUA DAVIS	Shareholder	Administrative	.25%	SEE ATACHED	0.4	1.00	Salary	2,115	17-1	5
6	AHUVA WEINREB	Shareholder	Administrative	.25%	SEE ATACHED	5	25.00	Alloc. Sal	(92)	17-7	6
7	AHUVA WEINREB	Shareholder	Administrative	.25%	SEE ATACHED	5	25.00	Salary	13,462	17-1	7
8	MOSHE WOLF	Shareholder	Administrative	1.34%	SEE ATACHED	12	21.42	Alloc. Sal	986	17-7	8
9	MOSHE WOLF	Shareholder	Administrative	1.34%	SEE ATACHED	12	21.42	Alloc. Sal	14,584	17-7	9
10	RENITA O'CONNELL	Shareholder	Administrative	1.34%	SEE ATACHED	9	22.50	Alloc. Sal	16,342	17-7	10
11	SHOSHANA BRAUN	Shareholder	Clerical	.25%	SEE ATACHED	3	21.58	Alloc. Sal	1,838	21-7	11
12											12
13								TOTAL	\$ 113,294		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:

01/01/00

Ending: 12/31/00

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/00

Ending: 12/31/00

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 MANAGCARE, INC.
 Street Address 3553 W. PETERSON AVE -3RD FLR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	HOUSEKEEPING	BOOKEEPING INC.	996,360	4	\$ 3,420	\$ 215,280	\$ 739	1	
2	5	UTILITIES	BOOKEEPING INC.	996,360	4	5,512	215,280	1,191	2	
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	996,360	4	12,353	215,280	2,669	3	
4	10	NURSING SALARIES	BOOKEEPING INC.	996,360	4	(2,266)	(2,266)	215,280	(490)	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	996,360	4	245,581	245,581	215,280	53,062	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	996,360	4	1,820	215,280	393	6	
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	996,360	4	1,190	215,280	257	7	
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	996,360	4	366,796	292,203	215,280	79,252	8
9	24	SEMINARS	BOOKEEPING INC.	996,360	4	7,624	215,280	1,647	9	
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	996,360	4	708	215,280	153	10	
11	26	INSURANCE	BOOKEEPING INC.	996,360	4	3,452	215,280	746	11	
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	996,360	4	124,135	215,280	26,821	12	
13	30	DEPRECIATION	BOOKEEPING INC.	996,360	4	32,945	215,280	7,118	13	
14	32	INTEREST EXPENSE	BOOKEEPING INC.	996,360	4	464	215,280	100	14	
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	996,360	4	45,600	215,280	9,853	15	
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	996,360	4	4,000	215,280	864	16	
17									17	
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	(3,475)	(3,475)	13	(1,148)	18
19	17	ADMIN. SALARY - AHUVA WE	AVG HRS WORKED	20	4	(3,205)	(3,205)	5	(801)	19
20	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	(3,537)	(3,537)	0	(33)	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 843,117	\$ 525,301	\$ 182,393	25	

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 INTERCARE, LTD. C/O MANAGCARE
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	\$ 103,000	\$ 103,000	5	\$ 8,583	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	2,330		5	194	2
3	20	FEEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	25		5	2	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	44		5	4	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	6,328		5	527	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	95		5	8	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					\$ 111,822	\$ 103,000		\$ 9,318	25

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 MAZEL MANAGEMENT
 Street Address 3553 W.PETERSON AVE.
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC. 996,360	4	\$ 6,120	\$	215,280	\$ 1,322	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC. 996,360	4	4,420	1,820	215,280	955	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC. 996,360	4	139		215,280	30	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC. 996,360	4	4,562		215,280	986	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC. 996,360	4	620		215,280	134	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC. 996,360	4	44		215,280	9	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC. 996,360	4	470		215,280	102	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC. 996,360	4	549		215,280	119	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC. 996,360	4	6,392		215,280	1,381	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC. 996,360	4	12,167		215,280	2,629	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC. 996,360	4	10,593		215,280	2,289	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				\$ 46,076	\$ 1,820		\$ 9,956	25

Facility Name & ID Number MAYFIELD CARE CENTER

0029660 Report Period Beginning: 01/01/00

Ending: 12/31/00

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:

01/01/00

Ending: 12/31/00

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:

01/01/00

Ending: 12/31/00

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:

01/01/00

Ending: 12/31/00

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:

01/01/00

Ending: 12/31/00

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:

01/01/00

Ending: 12/31/00

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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										
										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	N/P MANUFACTURERS		X	MORTGAGE			\$	\$		\$	1								
2	N/P GMAC		X	MORTGAGE				5,384,360			429,353	2							
3	N/P MANUFACTURERS		X	LINE OF CREDIT				50,000			12,609	3							
4												4							
5												5							
Working Capital																			
6	PROVIDENT LIFE		X	INSURANCE				1,146				6							
7	AT&T CAPITAL CORP		X	PHONE SYSTEM	\$258.00	10-96	9,896	2,362			699	7							
8								3,694				8							
9	TOTAL Facility Related				\$258.00		\$ 9,896	\$ 5,441,562			\$ 442,661	9							
B. Non-Facility Related*																			
10	Supplemental Schedule										(628)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (628)	14							
15	TOTALS (line 9+line14)						\$ 9,896	\$ 5,441,562			\$ 442,033	15							

* 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:

01/01/00

Ending:

12/31/00

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	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	11
		YES	NO				Original	Balance				
1	INTEREST INCOME						\$	\$			\$ (3,357)	1
2	ALLOCATION - MANAGCARE	X									100	2
3	ALLOCATION - MAZEL	X									2,629	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							\$	\$			\$ (628)	21

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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, nurse aide 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 NO
 If so, please complete the following:

1. Total Amount Incurred: 128,202 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: ALLOCATED FROM MAYFIELD BUILDING

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>MAYFIELD BLDG.</u>		<u>2000</u>	<u>\$ 168,991</u>	1
2					2
3	TOTALS			\$ 168,991	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	156		1999		\$ 1,595,648	\$ 40,914	20	\$ 79,782	\$ 38,868	\$ 132,970	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AWING		2000		8,500		20	779	779	779	9
10	FENCE		2000		1,250		20	125	125	125	10
11	NEW PUMP UNIT		2000		6,800	80	20	340	260	323	11
12	SURVEY		2000		750	12	20	25	13	25	12
13	FIRE DAMPERS		2000		7,044	158	20	323	165	323	13
14	FIRE DAMPERS		2000		1,000	21	20	42	21	42	14
15	FIRE DAMPERS		2000		4,920	110	20	226	116	226	15
16	ALARM SYSTEM		2000		1,866	30	20	62	32	62	16
17	ELECTRICAL WORK		2000		4,814	56	20	121	65	121	17
18	CIRCUIT BREAKER/CMPR		2000		3,982	38	20	83	45	83	18
19	NEW MAIN LINES		2000		2,775	38	20	81	43	81	19
20											20
21											21
22											22
23											23
24	PAGE 12-2 REP TOTALS				992,368	21,067		49,620	28,553	107,304	24
25	PAGE 12-1 REP TOTALS				401,192	10,695		19,009	8,314	153,846	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				55,972	2,942		2,433	(509)	33,324	34
35	PAGE 12A TOTALS				33,298			1,664	1,664	2,940	35
36	TOTAL (lines 4 thru 35)				\$ 3,122,179	\$ 76,161		\$ 154,715	\$ 78,554	\$ 432,574	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.

Facility Name & ID Number MAYFIELD CARE CENTER# 0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		MAYFIELD BLDG - CONSTRUCT SUPPLIES		1999	1,223		20	61	61	97	9
10		MAYFIELD BLDG - ARCHITECT SUPPLIES		1999	2,082		20	104	104	165	10
11		MAYFIELD BLDG - CUBICLE CURTNS, TILE		1999	2,147		20	107	107	170	11
12		MAYFIELD BLDG - NURSE CALL SYSTEM		1999	419		20	21	21	27	12
13		MAYFIELD BLDG - ALARM SYSTEM		1999	1,081		20	54	54	126	13
14		MAYFIELD BLDG - PAINTING		1999	1,585		20	79	79	126	14
15		MAYFIELD BLDG - SEAL COATING		1999	1,791		20	90	90	165	15
16		MAYFIELD BLDG - INTERCOM SYSTEM		1999	847		20	42	42	78	16
17		MAYFIELD BLDG - VIDEO SECURITY SYSTEM		1999	2,266		20	113	113	207	17
18		MAYFIELD BLDG - CCTV SYSTEM		1999	2,184		20	109	109	200	18
19		MAYFIELD BLDG - CCTV SYSTEM		1999	1,559		20	78	78	143	19
20		MAYFIELD BLDG - PUBLIC ADDRESS SYSTEM		1999	880		20	44	44	80	20
21		MAYFIELD BLDG - WALK IN REFRIG REPAIR		1999	1,405		20	70	70	140	21
22		MAYFIELD BLDG - COPPER PIPE		1999	1,475		20	74	74	148	22
23		MAYFIELD BLDG - TELECOM SYSTEM		1999	1,105		20	55	55	91	23
24		MAYFIELD BLDG - FIRE PROTECTION		1999	3,290		20	165	165	343	24
25		MAYFIELD BLDG - HOT WATER SYSTEM		1999	1,576		20	79	79	211	25
26		MAYFIELD BLDG - ELECTRIC DOOR HOLDER		1999	527		20	26	26	30	26
27		MAYFIELD BLDG - CCTV SYSTEM		1999	1,154		20	58	58	68	27
28		MAYFIELD BLDG - NURSE CALL SYSTEM		1999	348		20	17	17	19	28
29		MAYFIELD BLDG - CCTV SYSTEM		1999	762		20	38	38	44	29
30		MAYFIELD BLDG - ALARM SYSTEM		1999	1,392		20	70	70	88	30
31		MAYFIELD BLDG - ROOF FLASHERS		1999	1,000		20	50	50	79	31
32		MAYFIELD BLDG - COPPER PIPE		1999	1,200		20	60	60	95	32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 33,298	\$		\$ 1,664	\$ 1,664	\$ 2,940	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1985	ALLOC-MAZ	\$ 22,291	\$ 1,159	20	\$ 743	\$ (416)	\$ 11,331	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	ALLOCATION - MANAGCARE		1997	2,599	325	20	260	(65)	888	9
10	ALLOCATION - MANAGCARE		1993	204	11	20	10	(1)	77	10
11	ALLOCATION - MANAGCARE		1988	318	10	20	16	6	196	11
12	ALLOCATION - MANAGCARE		1986	24,107	1,231	20	1,104	(127)	17,854	12
13										13
14	ALLOCATION - MAZEL MANAGEMENT		2000	237	1	20	3	2	3	14
15	ALLOCATION - MAZEL MANAGEMENT		1998	834	28	20	42	14	113	15
16	ALLOCATION - MAZEL MANAGEMENT		1997	778	20	20	39	19	130	16
17	ALLOCATION - MAZEL MANAGEMENT		1996	530	12	20	27	15	121	17
18	ALLOCATION - MAZEL MANAGEMENT		1995	120	3	20	6	3	33	18
19	ALLOCATION - MAZEL MANAGEMENT		1994	473	9	20	24	15	129	19
20	ALLOCATION - MAZEL MANAGEMENT		1993	280	8	20	14	6	104	20
21	ALLOCATION - MAZEL MANAGEMENT		1991	210	7	20	10	3	92	21
22	ALLOCATION - MAZEL MANAGEMENT		1990	325	7	20	16	9	169	22
23	ALLOCATION - MAZEL MANAGEMENT		1989	204	5	20	9	4	99	23
24	ALLOCATION - MAZEL MANAGEMENT		1987	463	9	20	12	3	443	24
25	ALLOCATION - MAZEL MANAGEMENT		1986	1,869	97	20	98	1	1,412	25
26	ALLOCATION - MAZEL MANAGEMENT		1985	130					130	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)			\$ 55,972	\$ 2,942		\$ 2,433	\$ (509)	\$ 33,324	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

Facility Name & ID Number MAYFIELD CARE CENTER# 0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MAYFIELD BLDG - VARIOUS		1985		11,950	598	20	664	66	10,411	9
10	MAYFIELD BLDG - VARIOUS		1986		24,199	1,258	20	1,273	15	18,355	10
11	MAYFIELD BLDG - VARIOUS		1987		12,137	386	20	392	6	5,322	11
12	MAYFIELD BLDG - VARIOUS		1988		38,957	1,237	20	1,258	21	15,815	12
13	MAYFIELD BLDG - VARIOUS		1989		57,789	1,569	20	2,890	1,321	33,359	13
14	MAYFIELD BLDG - VARIOUS		1990		40,078	847	20	1,727	880	21,548	14
15	MAYFIELD BLDG - VARIOUS		1991		34,073	1,082	20	1,704	622	15,763	15
16	MAYFIELD BLDG - VARIOUS		1992		1,200	38	20	60	22	530	16
17	MAYFIELD BLDG - VARIOUS		1993		6,071	155	20	304	149	2,239	17
18	MAYFIELD BLDG - VARIOUS		1994		24,281	376	20	1,214	838	7,560	18
19	MAYFIELD BLDG - VARIOUS		1995		1,467	92	20	73	(19)	397	19
20	MAYFIELD BLDG - PANEL DRAPES		1996		3,234	83	20	162	79	729	20
21	MAYFIELD BLDG - FIRE PUMP		1996		2,640	68	20	132	64	605	21
22	MAYFIELD BLDG - ELECTRIC WORK		1996		4,500	115	20	225	110	1,013	22
23	MAYFIELD BLDG - HVAC		1996		1,875	48	20	94	46	423	23
24	MAYFIELD BLDG - A/C OPENINGS		1996		5,000	128	20	250	122	1,125	24
25	MAYFIELD BLDG - ELECTRIC WORK		1996		3,600	92	20	180	88	855	25
26	MAYFIELD BLDG - ELECTRIC WORK		1996		1,580	41	20	79	38	369	26
27	MAYFIELD BLDG - HOT WATER SYSTEM		1997		13,523	347	20	676	329	2,591	27
28	MAYFIELD BLDG - ROOF REPAIRS		1998		2,400	62	20	120	58	360	28
29	MAYFIELD BLDG - BATHROOM FLOORING		1998		1,379	35	20	69	34	173	29
30	MAYFIELD BLDG - BATHROOM FLOORING		1998		6,482	166	20	324	158	810	30
31	MAYFIELD BLDG - ASPHALT PAVING		1998		12,815	1,096	20	641	(455)	1,496	31
32	MAYFIELD BLDG - AT&T PHONE SYSTEM		1996		4,586		20	229	229	1,491	32
33	MAYFIELD BLDG - ALARM SYSTEM		1998		28,998	744	20	1,450	706	3,021	33
34	MAYFIELD BLDG - FIRE PUMP		1998		1,244	32	20	62	30	134	34
35	MAYFIELD BLDG - TILE, WALLPAPER, FIXT		1998		55,134		20	2,757	2,757	7,352	35
36	TOTAL (lines 4 thru 35)				\$ 401,192	\$ 10,695		\$ 19,009	\$ 8,314	\$ 153,846	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.

Facility Name & ID Number MAYFIELD CARE CENTER# 0029660

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		MAYFILED BLDG - HANDRAIL		1998	2,500		20	125	125	313	9
10		MAYFILED BLDG - HANDRAIL		1998	1,250		20	63	63	152	10
11		MAYFILED BLDG - CHAIN LINK FENCE		1998	1,580		20	79	79	171	11
12		MAYFILED BLDG - FIRE PUMP & MOTOR		1999	9,249	237	20	462	225	847	12
13		MAYFILED BLDG - ELECTRICAL WORK		1999	5,351	137	20	268	131	447	13
14		MAYFILED BLDG - FENCE		1999	6,975	663	20	349	(314)	611	14
15		MAYFILED BLDG - FIRE ALARM SYSTEM		1999	5,563		20	278	278	440	15
16		MAYFILED BLDG - STAIRWAY WORK		1999	2,850		20	143	143	286	16
17		MAYFILED BLDG - FLOOR DRAINS		1999	2,000		20	100	100	158	17
18		MAYFILED BLDG - BLDG RENOVATION		1998	804,722	19,063	20	40,236	21,173	83,924	18
19		MAYFILED BLDG - ALARM		1999	4,507		20	225	225	450	19
20		MAYFILED BLDG - VIDEO PROCESSOR		1999	3,832		20	192	192	224	20
21		MAYFILED BLDG - WALLPAPER		1998	5,240		20	262	262	699	21
22		MAYFILED BLDG - TILE, WALLPAPER, FIXT		1998	6,695		20	335	335	865	22
23		MAYFILED BLDG - WALLPAPER		1998	6,391		20	320	320	880	23
24		MAYFILED BLDG - WINDOWS		1996	37,125	967	20	1,856	889	7,956	24
25		MAYFILED BLDG - DESKS & CABINETS		1999	2,600		20	130	130	260	25
26		MAYFILED BLDG - DESKS & CABINETS		1999	5,825		20	291	291	315	26
27		MAYFILED BLDG - ELEVATOR DOOR RESTR.		1997	2,400		20	120	120	240	27
28		MAYFILED BLDG - DRAPES		1998	12,491		20	625	625	1,610	28
29		MAYFILED BLDG - DRAPES		1998	14,636		20	732	732	2,501	29
30		MAYFILED BLDG - SPRINKLER HEADS		1998	1,791		20	90	90	240	30
31		MAYFILED BLDG - LIGHT FIXTURES		1998	566		20	28	28	66	31
32		MAYFILED BLDG - BATHTUB		1999	1,220		20	61	61	76	32
33		MAYFILED BLDG - ELECTRICAL ENGINEER		1999	1,260		2	63	63	100	33
34		MAYFILED BLDG - PAINTING		1999	3,300		20	165	165	271	34
35		MAYFILED BLDG - REMODELING		1999	40,449		20	2,022	2,022	3,202	35
36		TOTAL (lines 4 thru 35)			\$ 992,368	\$ 21,067		\$ 49,620	\$ 28,553	\$ 107,304	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 805,689	\$ 179,659	\$ 80,875	\$ (98,784)		\$ 241,752	37
38	Current Year Purchases	44,812	10,552	2,396	(8,156)		2,294	38
39	Fully Depreciated Assets	89,684	8	495	487		89,684	39
40								40
41	TOTALS	\$ 940,185	\$ 190,219	\$ 83,766	\$ (106,453)		\$ 333,730	41

D. Vehicle Depreciation (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	
42				\$	\$	\$	\$		\$	42
43		ALLOC - MANAGCARE		9,796	1,015	1,046	31	5	6,151	43
44		ALLOC-MAYFIELD BLDG		22,962		4,210	4,210	5	8,802	44
45										45
46	TOTALS			\$ 32,758	\$ 1,015	\$ 5,256	\$ 4,241		\$ 14,953	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,264,113	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 267,395	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 243,737	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (23,658)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 781,257	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	CERTIFICATE OF NEED	\$ 905,000	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 905,000	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

MAYFIELD CARE CENTER
0029660
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
MAYFIELD CARE CENTER					
MAYFIELD BUILDING	783,282	175,916	78,456	(97,460)	232,683
ALLOCATED - MANAGCARE	22,302	3,727	2,409	(1,318)	9,030
ALLOCATED - INTERCARE					
ALLOCATED - MAZEL MANAGEMENT	105	16	10	(6)	39
TOTALS	805,689	179,659	80,875	(98,784)	241,752

LINE 29: CURRENT YEAR

MAYFIELD CARE CENTER	44,013	9,753	2,342	(7,411)	2,240
MAYFIELD BUILDING					
ALLOCATED - MANAGCARE	799	799	54	(745)	54
ALLOCATED - INTERCARE					
ALLOCATED - MAZEL MANAGEMENT					
TOTALS	44,812	10,552	2,396	(8,156)	2,294

LINE 30: FULLY DEPRECIATED

MAYFIELD CARE CENTER					
MAYFIELD BUILDING	58,384				58,384
ALLOCATED - MANAGCARE	29,837		485	485	29,837
ALLOCATED - INTERCARE	1,281	8	10	2	1,281
ALLOCATED - MAZEL MANAGEMENT	182				182
TOTALS	89,684	8	495	487	89,684

TOTALS (Should Tie to Totals on Page 13)

MAYFIELD CARE CENTER	44,013	9,753	2,342	(7,411)	2,240
MAYFIELD BUILDING	841,666	175,916	78,456	(97,460)	291,067
ALLOCATED - MANAGCARE	52,938	4,526	2,948	(1,578)	38,921
ALLOCATED - INTERCARE	1,281	8	10	2	1,281
ALLOCATED - MAZEL MANAGEMENT	287	16	10	(6)	221
TOTALS	940,185	190,219	83,766	(106,453)	333,730

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning:

01/01/00

Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MAYFIELD BUILDING

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 24,855

Description: COMPLEX MEDICAL EQUIPMENT

(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	<u>ALLOC-MANAGCARE</u>		\$	\$ <u>864</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>864</u>	21

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. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* 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.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

1	Service	Schedule V Line & Column Reference	2 Staff		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$		\$				\$				1
2	Licensed Speech and Language Development Therapist	39-3	hrs			17,201									17,201	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39-3	hrs			42,106									42,106	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts							37,946					37,946	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-3								37,527					37,527	13
14	TOTAL			\$		\$	59,307	\$	75,473			\$		134,780		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 nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 89,678	\$ 89,778 1
2	Cash-Patient Deposits	45,113	45,113 2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,274,068	1,274,068 3
4	Supply Inventory (priced at)		
5	Short-Term Investments		
6	Prepaid Insurance	112,872	112,872 6
7	Other Prepaid Expenses	3,904	3,904 7
8	Accounts Receivable (owners or related parties)	38,862	38,862 8
9	Other(specify): See supplemental schedule	306,446	316,446 9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,870,943	\$ 1,881,043 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		
12	Long-Term Investments		
13	Land		273,991 13
14	Buildings, at Historical Cost		1,595,648 14
15	Leasehold Improvements, at Historical Cos	31,128	1,146,152 15
16	Equipment, at Historical Cost	56,459	1,099,971 16
17	Accumulated Depreciation (book methods)	(10,296)	(880,414) 17
18	Deferred Charges		
19	Organization & Pre-Operating Costs	209,375	337,577 19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(99,190) 20
21	Restricted Funds		
22	Other Long-Term Assets (specify):		905,000 22
23	Other(specify): See supplemental schedule		
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 286,666	\$ 4,378,735 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,157,609	\$ 6,259,778 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 766,749	\$ 766,749 26
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable	806,634	4,840 29
30	Accrued Salaries Payable	106,626	106,626 30
31	Accrued Taxes Payable (excluding real estate taxes)	25,146	25,146 31
32	Accrued Real Estate Taxes(Sch.IX-B)		47,000 32
33	Accrued Interest Payable	449	449 33
34	Deferred Compensation		
35	Federal and State Income Taxes		
Other Current Liabilities(specify):			
36	See supplemental schedule	122	122 36
37			
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,705,726	\$ 950,932 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	52,362	5,436,722 39
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
Other Long-Term Liabilities(specify):			
43	See supplemental schedule		
44			
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 52,362	\$ 5,436,722 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,758,088	\$ 6,387,654 46
47	TOTAL EQUITY(page 18, line 24)	\$ 399,521	\$ #REF! 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,157,609	\$ #REF! 48

*(See instructions.)

Facility Name & ID Number **MAYFIELD CARE CENTER**

0029660

Report Period Beginning: **01/01/00**

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of **12/31/00**

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
REAL ESTATE TAX ESCROW	17,807	17,807
EMPLOYEE ADVANCES	2,359	2,359
CAPITAL CONTRIBUTIONS RECEIVABLE		10,000
FHA REPLACEMENT RESERVE	191,347	191,347
FHA MORTGAGE INSURANCE ESCROW	27,071	27,071
HAZARD INSURANCE ESCROW	67,862	67,862

	<u>306,446</u>	<u>316,446</u>
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OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
DUE TO OTHERS	122	304,209

	<u>122</u>	<u>304,209</u>
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OTHER NON CURRENT ASSETS:

CERTIFICATE OF NEED	905,000
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	<u>905,000</u>
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OTHER NON CURRENT LIABILITIES:

	<u></u>
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XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 420,403	1
2	Restatements (describe):		2
3	Schedule attached	(76,058)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 344,345	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,176	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	(260,000)	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)	\$ 55,176	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)	\$ 399,521	24 *

* This must agree with page 17, line 47.

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.

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,488,407	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,488,407	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,462	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 279,462	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,357	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,357	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	4,610	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,610	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,775,836	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,026,159	31
32	Health Care	1,970,297	32
33	General Administration	1,492,254	33
B. Capital Expense			
34	Ownership	667,095	34
C. Ancillary Expense			
35	Special Cost Centers	219,211	35
36	Provider Participation Fee	85,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,460,660	40
41	Income before Income Taxes (line 30 minus line 40)**	315,176	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 315,176	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

<u>DESCRIPTION</u>	<u>AMOUNT</u>
1 VENDING COMMISSIONS	1,409
2 OFFICERS LIFE INSURANCE	2,673
3 MISC. INCOME (ADJUSTED OFF ON PAGE 5)	528
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>4,610</u></u>

Facility Name & ID Number MAYFIELD CARE CENTER

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,040	\$ 60,028	\$ 29.43	1
2	Assistant Director of Nursing	2,646	2,934	64,893	22.12	2
3	Registered Nurses	9,988	10,814	199,397	18.44	3
4	Licensed Practical Nurses	33,038	36,346	550,712	15.15	4
5	Nurse Aides & Orderlies	82,204	87,650	698,186	7.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,693	8,651	100,096	11.57	8
9	Activity Director	1,832	1,880	24,843	13.21	9
10	Activity Assistants	6,774	7,180	48,486	6.75	10
11	Social Service Workers	6,226	6,742	63,020	9.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,981	26,218	215,827	8.23	15
16	Dishwashers					16
17	Maintenance Workers	8,772	9,001	68,775	7.64	17
18	Housekeepers	22,715	24,199	162,967	6.73	18
19	Laundry	9,270	10,202	65,484	6.42	19
20	Administrator	2,032	2,160	69,314	32.09	20
21	Assistant Administrator	2,133	2,164	36,782	17.00	21
22	Other Administrative	4,840	4,840	95,058	19.64	22
23	Office Manager					23
24	Clerical	5,382	5,410	63,992	11.83	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					31
32	Other Health Care(specify)					32
33	Other(specify)	2,211	3,067	79,868	26.04	33
34	TOTAL (lines 1 - 33)	233,737	251,498	\$ 2,667,728 *	\$ 10.61	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	235	\$ 12,000	3-1	35
36	Medical Director	MONTHLY	6,000	3-9	36
37	Medical Records Consultant	MONTHLY	4,032	3-10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,872	3-10	39
40	Physical Therapy Consultant	46	2,398	3-10A	40
41	Occupational Therapy Consultant	36	1,879	3-10A	41
42	Respiratory Therapy Consultant	14	810	3-10	42
43	Speech Therapy Consultant	1	48	3-10A	43
44	Activity Consultant	49	2,619	3-11	44
45	Social Service Consultant	73	3,942	3-12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	454	\$ 35,600		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$ 0		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
MARKETING SALARIES	2,211	3,067	\$ 79,868	\$ 26.04
	<u>2,211</u>	<u>3,067</u>	<u>\$ 79,868</u>	<u>\$ 26.04</u>

Facility Name & ID Number MAYFIELD CARE CENTER

0029660

Report Period Beginning: 01/01/00

Ending: 12/31/00

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 - 4464.00
- (3) Did the nursing home make political contributions or payments to a political 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? _____
- (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. \$ 904 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 85,644
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 of Public Aid, 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 benefit on Schedule V. \$ 29,953 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
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? _____
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/ov