



Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,208		4,828	21,036	8
9	SNF/PED					9
10	ICF	21,792	343		22,135	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,000	343	4,828	43,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.82%

D. How many bed-hold days during this year were paid by the Department?

N/A (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 01/01/1985

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 104 and days of care provided 4,395

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	221,088	37,957	12,124	271,169		271,169		271,169		1
2	Food Purchase		215,885		215,885	(26,645)	189,240	(17)	189,223		2
3	Housekeeping	230,608	56,066		286,674		286,674	1,269	287,943		3
4	Laundry	96,822	10,816		107,638		107,638		107,638		4
5	Heat and Other Utilities			157,787	157,787		157,787	3,305	161,092		5
6	Maintenance	63,601	21,125	28,540	113,266		113,266	3,821	117,087		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>612,119</b>	<b>341,849</b>	<b>198,451</b>	<b>1,152,419</b>	<b>(26,645)</b>	<b>1,125,774</b>	<b>8,378</b>	<b>1,134,152</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			33,950	33,950		33,950	(300)	33,650		9
10	Nursing and Medical Records	2,010,738	80,115	162,052	2,252,905		2,252,905		2,252,905		10
10a	Therapy	112,572		12,270	124,842		124,842		124,842		10a
11	Activities	85,569	13,113		98,682		98,682		98,682		11
12	Social Services	96,269		5,034	101,303		101,303		101,303		12
13	CNA Training										13
14	Program Transportation			264	264		264		264		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,305,148</b>	<b>93,228</b>	<b>213,570</b>	<b>2,611,946</b>		<b>2,611,946</b>	<b>(300)</b>	<b>2,611,646</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	206,584		72,000	278,584		278,584	(370)	278,214		17
18	Directors Fees										18
19	Professional Services			423,118	423,118	(33,090)	390,028	(284,782)	105,246		19
20	Dues, Fees, Subscriptions & Promotions			51,757	51,757		51,757	(29,411)	22,346		20
21	Clerical & General Office Expenses	48,720	31,753	279,316	359,789		359,789	(128,224)	231,565		21
22	Employee Benefits & Payroll Taxes			522,854	522,854	26,645	549,499		549,499		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,645	1,645		1,645	210	1,855		24
25	Other Admin. Staff Transportation			2,653	2,653		2,653	(288)	2,365		25
26	Insurance-Prop.Liab.Malpractice			45,815	45,815		45,815	143,405	189,220		26
27	Other (specify):*							47,345	47,345		27
28	<b>TOTAL General Administration</b>	<b>255,304</b>	<b>31,753</b>	<b>1,399,158</b>	<b>1,686,215</b>	<b>(6,445)</b>	<b>1,679,770</b>	<b>(252,115)</b>	<b>1,427,655</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,172,571</b>	<b>466,830</b>	<b>1,811,179</b>	<b>5,450,580</b>	<b>(33,090)</b>	<b>5,417,490</b>	<b>(244,037)</b>	<b>5,173,453</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mayfield Care Center #0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			5,766	5,766		5,766	226,291	232,057		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			27,307	27,307		27,307	237,128	264,435		32
33	Real Estate Taxes			1,137	1,137	33,090	34,227	53,260	87,487		33
34	Rent-Facility & Grounds			616,000	616,000		616,000	(616,000)			34
35	Rent-Equipment & Vehicles			10,525	10,525		10,525	(10,119)	406		35
36	Other (specify):*							26,396	26,396		36
37	<b>TOTAL Ownership</b>			660,735	660,735	33,090	693,825	(83,044)	610,781		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		218,240	405,876	624,116		624,116		624,116		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,410	85,410		85,410		85,410		42
43	Other (specify):*	162,409		2,113	164,522		164,522	(164,522)			43
44	<b>TOTAL Special Cost Centers</b>	162,409	218,240	493,399	874,048		874,048	(164,522)	709,526		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,334,980	685,070	2,965,313	6,985,363		6,985,363	(491,603)	6,493,760		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,529)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	145,362	30		9
10	Interest and Other Investment Income	(63,624)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,075)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(189,553)	21		24
25	Fund Raising, Advertising and Promotional	(20,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(273,891)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (411,318)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(80,285)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (80,285)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (491,603)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Maelfield Care Center  
 For 0029666  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

	Amount	Sch. V Line
<b>NON-ALLOWABLE EXPENSES</b>		
1 Theft & Loss	\$ (189)	21 1
2 Non-Allowable Office Expense	(23,483)	21 2
3 Marketing Consultant	(2,113)	43 3
4 C/P/L Dues	(1,994)	20 4
5 Marketing Salaries	(162,409)	43 5
6 Non-Allowable Legal Fees	(19,778)	19 6
7 Non-Allowable Auto Lease	(10,354)	38 7
8 Board of Elections	(25)	21 8
9 Jury Duty Income	(172)	21 9
10 Non-Allowable Travel Expense	(288)	25 10
11 Prior Period Medical Director	(300)	09 11
12 Prior Period Inspection Fees	(48)	20 12
13 Annual Reporting Fees- Building Co.	(150)	20 13
14 Accounting Fees- Building Co.	(15,600)	19 14
15 Legal & Professional Fees- Building Co.	(10,090)	19 15
16 Amortizations- Building Co.	(1,596)	31 16
17 Non-Allowable Accounting Fees	(5,000)	19 17
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99		99
100		100
101 Total	(273,894)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(17)											(17)	2
3	Housekeeping			798		471							1,269	3
4	Laundry													4
5	Heat and Other Utilities			1,413		1,892							3,305	5
6	Maintenance	(1,529)		4,637		713							3,821	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(1,546)</b>		<b>6,848</b>		<b>3,076</b>							<b>8,378</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	(300)											(300)	9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(300)</b>											<b>(300)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			64,358	(65,352)	624							(370)	17
18	Directors Fees													18
19	Professional Services	(70,468)	45,690	(260,692)	554	134							(284,782)	19
20	Fees, Subscriptions & Promotions	(30,358)	150	751	37	9							(29,411)	20
21	Clerical & General Office Expenses	(213,622)	37	85,016	238	107							(128,224)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			210									210	24
25	Other Admin. Staff Transportation	(288)											(288)	25
26	Insurance-Prop.Liab.Malpractice		142,846	381		178							143,405	26
27	Other (specify):*			46,772	573								47,345	27
28	<b>TOTAL General Administration</b>	<b>(314,736)</b>	<b>188,723</b>	<b>(63,204)</b>	<b>(63,950)</b>	<b>1,052</b>							<b>(252,115)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(316,582)</b>	<b>188,723</b>	<b>(56,356)</b>	<b>(63,950)</b>	<b>4,128</b>							<b>(244,037)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	145,362	77,960	2,703		266							226,291	30
31	Amortization of Pre-Op. & Org.	(1,598)	1,598											31
32	Interest	(63,624)	298,166	34		2,552							237,128	32
33	Real Estate Taxes		48,777			4,483							53,260	33
34	Rent-Facility & Grounds		(616,000)	11,967		(11,967)							(616,000)	34
35	Rent-Equipment & Vehicles	(10,354)		235									(10,119)	35
36	Other (specify):*		26,396										26,396	36
37	<b>TOTAL Ownership</b>	<b>69,786</b>	<b>(163,103)</b>	<b>14,939</b>		<b>(4,666)</b>							<b>(83,044)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(164,522)											(164,522)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(164,522)</b>											<b>(164,522)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(411,318)</b>	<b>25,620</b>	<b>(41,417)</b>	<b>(63,950)</b>	<b>(538)</b>							<b>(491,603)</b>	<b>45</b>

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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		
				Mayfield Building Limited		Building Co.

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 616,000	Mayfield Building Limited	100.00%	\$	\$ (616,000)	1
2	V	32 Interest Income	2,473	Mayfield Building Limited	100.00%		(2,473)	2
3	V	19 Legal & Professional Expense		Mayfield Building Limited	100.00%	30,090	30,090	3
4	V	32 Interest Expense		Mayfield Building Limited	100.00%	300,639	300,639	4
5	V	36 Mortgage Insurance		Mayfield Building Limited	100.00%	26,396	26,396	5
6	V	20 Annual Report Fees		Mayfield Building Limited	100.00%	150	150	6
7	V	26 Property Insurance		Mayfield Building Limited	100.00%	142,846	142,846	7
8	V	19 Accounting Fees		Mayfield Building Limited	100.00%	15,600	15,600	8
9	V	21 Office Expense		Mayfield Building Limited	100.00%	37	37	9
10	V	30 Depreciation Expense		Mayfield Building Limited	100.00%	77,960	77,960	10
11	V	31 Amortization		Mayfield Building Limited	100.00%	1,598	1,598	11
12	V	33 Real Estate Tax Expense		Mayfield Building Limited	100.00%	48,777	48,777	12
13	V							13
14	Total		\$ 618,473			\$ 644,093	\$ * 25,620	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 798	\$ 798	15
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,413	1,413	16
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	4,637	4,637	17
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	64,358	64,358	19
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	824	824	20
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	751	751	21
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	85,016	85,016	22
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	210	210	23
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%			24
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	381	381	25
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	46,772	46,772	26
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	2,703	2,703	27
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	34	34	28
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,967	11,967	29
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	235	235	30
31	V	19 HOME OFFICE	261,516	MANAGCARE, INC.	100.00%		(261,516)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 261,516			\$ 220,099	\$ * (41,417)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 6,648	\$ 6,648	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	554	554	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	37	37	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	238	238	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	573	573	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%			20
21	V								21
22	V	17	MANAGEMENT FEES	72,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(72,000)	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			\$ 72,000			\$ 8,050	\$ * (63,950)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	MAZEL MANAGEMENT	100.00%	\$ 471	\$ 471	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		1,892	1,892	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		713	713	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		624	624	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		134	134	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		9	9	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		107	107	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		178	178	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		266	266	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,552	2,552	26
27	V	33 REAL ESTATE TAXES				4,483	4,483	27
28	V							28
29	V	34 RENT	11,967				(11,967)	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		\$ 11,967			\$ 11,429	\$ * (538)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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	68.37%	See Attached	4.43	12.66%	Sal./Al.Salary	\$ 21,648	17-1, 17-7	1
2	Renee Wolf	Relative	Clerical		See Attached	9.33	23.33%	Alloc. Salary	4,359	21-7	2
3	Moshe Wolf	Shareholder	Administrative	1.34%	See Attached	13.06	23.32%	Al.Sal/Al.Fees	16,242	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.34%	See Attached	9.33	22.21%	Alloc. Salary	20,435	17-7	4
5	Moshe Davis	Shareholder	Mgmt/Admin	0.56%	See Attached	38	67.86%	Alloc. Salary	113,145	17-1	5
6	Yehoshua Davis	Shareholder	Administrative	0.56%	See Attached	2	3.64%	Alloc. Salary	10,507	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 186,336		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

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

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

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	PATIENT DAYS	185,062	3	\$ 3,420	\$ 43,171	\$ 798	1
2	5	UTILITIES	PATIENT DAYS	185,062	3	6,058	43,171	1,413	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	185,062	3	19,878	43,171	4,637	3
4	10	NURSING SALARIES	PATIENT DAYS	185,062	3		43,171		4
5	17	ADMINISTRATIVE	PATIENT DAYS	185,062	3	275,883	275,883	64,358	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	185,062	3	3,533	43,171	824	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	185,062	3	3,218	43,171	751	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	185,062	3	364,441	310,057	85,016	8
9	24	SEMINARS	PATIENT DAYS	185,062	3	900	43,171	210	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	185,062	3		43,171		10
11	26	INSURANCE	PATIENT DAYS	185,062	3	1,634	43,171	381	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	185,062	3	200,496	43,171	46,772	12
13	30	DEPRECIATION	PATIENT DAYS	185,062	3	11,587	43,171	2,703	13
14	32	INTEREST EXPENSE	PATIENT DAYS	185,062	3	145	43,171	34	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	185,062	3	51,300	43,171	11,967	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	185,062	3	1,006	43,171	235	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 943,499	\$ 585,940		\$ 220,099	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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

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

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	17	ADMINISTRATIVE	AVG. HOURS WORKED 20	4	\$ 30,000	\$ 30,000	4.43	\$ 6,648	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 20	4	2,500		4.43	554	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED 20	4	166		4.43	37	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED 20	4	1,073		4.43	238	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 20	4	2,587		4.43	573	5
6	30	DEPRECIATION	AVG. HOURS WORKED 20	4			4.43		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				\$ 36,326	\$ 30,000		\$ 8,050	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	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	MNGCR. PATIENT DAYS	185,062	3	\$ 2,021	\$ 43,171	\$ 471	1
2	5	UTILITIES	MNGCR. PATIENT DAYS	185,062	3	8,112	43,171	1,892	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	185,062	3	3,058	43,171	713	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	185,062	3		43,171		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	185,062	3	2,676	43,171	624	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	185,062	3	573	43,171	134	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	185,062	3	40	43,171	9	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	185,062	3	460	43,171	107	8
9	26	INSURANCE	MNGCR. PATIENT DAYS	185,062	3	763	43,171	178	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS	185,062	3	1,141	43,171	266	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS	185,062	3		43,171		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	185,062	3	10,942	43,171	2,552	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	185,062	3	19,216	43,171	4,483	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					\$ 49,002	\$	\$ 11,429	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB Financial Bank		X	Line of Credit			\$	625,000		\$	27,307	1								
2	Greystone / Heartland		X					5,291,178			300,639	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Allocation from Managecare		X								34	6								
7	Allocation from Mazel Mgmt.		X								2,552	7								
8	See Supplemental Schedule											8								
9	<b>TOTAL Facility Related</b>						\$	5,916,178		\$	330,532	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(63,624)	10								
11	Interest Income (Bldg. Co.)										(2,473)	11								
12												12								
13	See Supplemental Schedule											13								
14	<b>TOTAL Non-Facility Related</b>						\$			\$	(66,097)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	5,916,178		\$	264,435	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,396 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number

Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>											7							
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>											14							
	<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>											20							

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-08-419-002-0000</u>	<u>Long Term Care Property</u>	<u>\$ 1,136.96</u>	<u>\$ 1,136.96</u>
2. <u>16-08-419-003-0000</u>	<u>Long Term Care Property</u>	<u>\$ 12,272.38</u>	<u>\$ 12,272.38</u>
3. <u>16-08-419-004-0000</u>	<u>Long Term Care Property</u>	<u>\$ 17,956.12</u>	<u>\$ 17,956.12</u>
4. <u>16-08-419-005-0000</u>	<u>Long Term Care Property</u>	<u>\$ 12,440.93</u>	<u>\$ 12,440.93</u>
5. <u>16-08-419-006-0000</u>	<u>Long Term Care Property</u>	<u>\$ 9,017.96</u>	<u>\$ 9,017.96</u>
6. <u>16-08-419-007-0000</u>	<u>Long Term Care Property</u>	<u>\$ 2,489.98</u>	<u>\$ 2,489.98</u>
7. <u>See Attached</u>	<u>Allocation From Managecare/Mazel</u>	<u>\$ 62,315.89</u>	<u>\$ 3,332.79</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 117,630.22</u>	<u>\$ 58,647.12</u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning:

01/01/07 Ending:

12/31/07

**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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2000</u>	\$ <u>168,991</u>	1
2					2
3	<b>TOTALS</b>			\$ <b>168,991</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1985	11,950		20			11,898	9
10	Various			1986	24,199		20			24,077	10
11	Various			1987	12,137		20	392	392	8,063	11
12	Various			1988	38,957		20	1,258	1,258	24,613	12
13	Various			1989	57,789		20	2,890	2,890	53,586	13
14	Various			1990	40,078		20	1,391	1,391	31,283	14
15	Various			1991	34,073		20	1,704	1,704	27,689	15
16	Various			1992	1,200		20	60	60	950	16
17	Various			1993	6,071		20	304	304	4,364	17
18	Various			1994	24,281		20	1,214	1,214	16,059	18
19	Various			1995	1,467		20	73	73	910	19
20	Various			1996	64,140		20	3,207	3,207	37,016	20
21	Various			1997	15,923		20	796	796	8,404	21
22	Various			1998	966,314		20	48,318	48,318	442,980	22
23	Various			1999	137,374		20	6,868	6,868	59,393	23
24	Various			2000	43,701		20	3,013	3,013	23,213	24
25	Various			2001	9,572		20	714	714	4,768	25
26	Various			2002	14,269		20	1,427	1,427	8,073	26
27	Various			2003	3,119		20	247	247	1,079	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,595,648	77,960		79,782	1,822	512,060	67
68		64,656	276		1,416	1,140	52,912	68
69			5,766			(5,766)		69
70		\$ 3,166,918	\$ 84,002		\$ 155,074	\$ 71,072	\$ 1,353,390	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,166,918	\$ 84,002		\$ 155,074	\$ 71,072	\$ 1,353,390	1
2	Water Heater	2004	9,826		20	819	819	3,207	2
3	Coil Type Heater	2004	3,027		20	605	605	2,371	3
4	Storage Tanks	2004	1,877		20	375	375	1,376	4
5	Elevator	2004	10,150		20	508	508	1,819	5
6	Elevator	2004	2,500		20	125	125	406	6
7	Elevator Repair	2004	940		20	47	47	168	7
8	Adjusted Elevator Door	2004	680		20	34	34	128	8
9	Service On Video Monitoring System	2004	588		20	29	29	96	9
10	Repair Walk-In Cooler	2004	928		20	46	46	147	10
11	Install New Smoke Detector	2004	595		20	30	30	109	11
12	Service On Video Monitoring System	2004	982		20	49	49	196	12
13	Detector Edges	2005	3,880		20	194	194	566	13
14	Fire Alarm System	2005	8,206		20	1,172	1,172	3,224	14
15	Hydraulic Packing	2005	2,500		20	125	125	344	15
16	A/C System Pump	2006	1,720		20	143	143	239	16
17	Detector Edge	2006	1,544		20	154	154	244	17
18	A/C Exv Valve/Repair	2006	3,683		20	307	307	460	18
19	Dome Ccd Camera	2006	1,216		20	243	243	263	19
20	Pyro Chem Fire System	2007	2,845		20	237	237	237	20
21	Monitoring System	2007	1,504		20	38	38	38	21
22	Color Dome Camera & Cctv	2007	1,933		20	81	81	81	22
23	Color Dome Camera	2007	1,699		20	127	127	127	23
24	Channel Color Multiplexor	2007	1,590		20	132	132	132	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,231,331	\$ 84,002		\$ 160,694	\$ 76,692	\$ 1,369,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

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**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156		1999	1973	\$ 1,595,648	\$ 77,960		\$ 79,782	\$ 1,822	\$ 512,060	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

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Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,595,648	\$ 77,960		\$ 79,782	\$ 1,822	\$ 512,060	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	Alloc. From Mazel Management		1985	1985	\$ 24,067	\$	20	\$ 802	\$ 802	\$ 17,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation- Managcare			1997	2,806	-	20	164	164	2,642	10
11	Allocation- Managcare			1993	220	-	20	11	11	149	11
12	Allocation- Managcare			1988	344	11	20	17	6	312	12
13	Allocation- Managcare			1986	26,028	-	20	-		26,026	13
14											14
15	Allocation- Mazel Management			2007	1,416	18	20	39	21	39	15
16	Allocation- Mazel Management			2006	759	19	20	38	19	57	16
17	Allocation- Mazel Management			2005	568	99	20	57	(42)	141	17
18	Allocation- Mazel Management			2001	505	13	20	25	12	164	18
19	Allocation- Mazel Management			2000	255	7	20	13	6	93	19
20	Allocation- Mazel Management			1998	900	31	20	45	14	437	20
21	Allocation- Mazel Management			1997	840	22	20	42	20	434	21
22	Allocation- Mazel Management			1996	573	6	20	29	23	331	22
23	Allocation- Mazel Management			1995	129	3	20	6	3	81	23
24	Allocation- Mazel Management			1994	511	9	20	26	17	318	24
25	Allocation- Mazel Management			1993	302	9	20	15	6	218	25
26	Allocation- Mazel Management			1991	226	7	20	11	4	177	26
27	Allocation- Mazel Management			1990	351	7	20	18	11	305	27
28	Allocation- Mazel Management			1989	220	5	20	9	4	171	28
29	Allocation- Mazel Management			1987	500	10	20	-	(10)	500	29
30	Allocation- Mazel Management			1986	2,017	-	20	-		2,017	30
31	Allocation- Mazel Management			1985	140	-	20	-		140	31
32											32
33	Allocation- Intercare			2001	979		20	49	49	310	33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			64,656	276	1,416	1,140	52,912	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	
71	Purchased in Prior Years	\$ 789,070	\$ 561	\$ 70,199	\$ 69,638	10	\$ 692,867	71
72	Current Year Purchases	5,836		310	310	10	310	72
73	Fully Depreciated Assets	207,549	52		(52)	10	156,676	73
74								74
75	TOTALS	\$ 1,002,455	\$ 613	\$ 70,509	\$ 69,896		\$ 849,853	75

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	
76		ALLOC MANAGECARE	2007	\$ 9,222	\$ 2,079	\$ 853	\$ (1,226)	5	\$ 14,157	76
77										77
78										78
79										79
80	TOTALS			\$ 9,222	\$ 2,079	\$ 853	\$ (1,226)		\$ 14,157	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,411,999	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,694	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,056	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 145,362	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,233,378	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/07

Ending: 12/31/07

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES  NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 406

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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 CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 196,636	\$		\$ 196,636	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,120			21,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			187,049			187,049	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				108,272		108,272	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					25,044		25,044	12
13	Other (specify): <u>See Supplemental</u>					1,071	84,924		85,995	13
14	<b>TOTAL</b>			\$		\$ 405,876	\$ 218,240		\$ 624,116	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center# 0029660Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 25,844	\$ 67,293	1
2	Cash-Patient Deposits	2,970	2,970	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	908,556	908,556	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,507	181,642	6
7	Other Prepaid Expenses	7,255	7,255	7
8	Accounts Receivable (owners or related parties)	693,117	693,117	8
9	Other(specify): <u>See Attached Schedule</u>	37,827	111,848	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,744,076	\$ 1,972,681	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,000	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	107,219	1,350,392	15
16	Equipment, at Historical Cost	102,958	1,221,952	16
17	Accumulated Depreciation (book methods)	(136,543)	(1,943,965)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	6,095	1,193,371	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 79,729	\$ 3,522,398	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,823,805	\$ 5,495,079	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 715,909	\$ 715,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	201,442	201,442	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,702	13,702	31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,300	32
33	Accrued Interest Payable	1,724	1,724	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	1,278	1,278	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 934,055	\$ 989,357	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	625,000	625,000	39
40	Mortgage Payable		5,291,178	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 625,000	\$ 5,916,178	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,559,055	\$ 6,905,535	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 264,750	\$ (1,410,456)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,823,805	\$ 5,495,079	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 555,608	1
2	Restatements (describe):		2
3	<u>Depreciation</u>	9,000	3
4	<u>Rounding</u>	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 564,606	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(299,856)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (299,856)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 264,750	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,492,272	1
2	Discounts and Allowances for all Levels	(830,329)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,661,943</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	758,996	6
7	Oxygen	1,129	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 760,125</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	137,040	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,922	19
20	Radiology and X-Ray	530	20
21	Other Medical Services	47,925	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 195,417</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	63,624	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 63,624</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	4,398	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 4,398</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,685,507</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,152,419	31
32	Health Care	2,611,946	32
33	General Administration	1,686,215	33
<b>B. Capital Expense</b>			
34	Ownership	660,735	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	788,638	35
36	Provider Participation Fee	85,410	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,985,363</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(299,856)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (299,856)</b>	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	11,391	12,436	393,572	31.65	3
4	Licensed Practical Nurses	31,426	33,696	748,751	22.22	4
5	CNAs & Orderlies	75,543	82,548	818,179	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,951	7,836	112,572	14.37	8
9	Activity Director	1,918	2,198	26,688	12.14	9
10	Activity Assistants	5,518	6,324	58,881	9.31	10
11	Social Service Workers	5,579	6,211	96,269	15.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,531	21,599	221,088	10.24	15
16	Dishwashers					16
17	Maintenance Workers	7,323	8,076	63,601	7.88	17
18	Housekeepers	21,827	24,338	230,608	9.48	18
19	Laundry	8,860	10,249	96,822	9.45	19
20	Administrator	784	892	38,403	43.05	20
21	Assistant Administrator	1,168	1,480	29,529	19.95	21
22	Other Administrative	4,912	4,912	138,652	28.23	22
23	Office Manager					23
24	Clerical	3,329	3,513	48,720	13.87	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	3,437	3,615	50,236	13.90	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,598	5,790	162,409	28.05	33
34	TOTAL (lines 1 - 33)	215,095	235,713	\$ 3,334,980 *	\$ 14.15	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	295	\$ 12,124	01-03	35
36	Medical Director	Monthly	33,950	09-03	36
37	Medical Records Consultant	Monthly	2,112	10-03	37
38	Nurse Consultant	80	6,665	10-03	38
39	Pharmacist Consultant	Monthly	3,445	10-03	39
40	Physical Therapy Consultant	73	4,169	10a-03	40
41	Occupational Therapy Consultant	105	6,066	10a-03	41
42	Respiratory Therapy Consultant	53	1,915	10a-03	42
43	Speech Therapy Consultant	2	120	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	90	5,034	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	698	\$ 75,600		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	4,625	149,830	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,625	\$ 149,830		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Mayfield Care Center

Report Period Beginning: 01/01/07 Ending:

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Mayfield Care Center

**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 \$8,447
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,021 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,410  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 26,645 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT