



Facility Name & ID Number Mayfield Care Center

# 0029660 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,457		4,174	22,631	8
9	SNF/PED					9
10	ICF	20,835	242		21,077	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,292	242	4,174	43,708	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.55%

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 1/1/1985

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 3,880

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	227,244	43,607	13,355	284,206		284,206		284,206		1
2	Food Purchase		230,014		230,014	(27,816)	202,198	(13)	202,185		2
3	Housekeeping	246,265	77,735		324,000		324,000	1,257	325,257		3
4	Laundry	78,440	14,007		92,447		92,447		92,447		4
5	Heat and Other Utilities			176,568	176,568		176,568	3,049	179,617		5
6	Maintenance	65,619	17,649	38,689	121,957		121,957	2,751	124,708		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>617,568</b>	<b>383,012</b>	<b>228,612</b>	<b>1,229,192</b>	<b>(27,816)</b>	<b>1,201,376</b>	<b>7,044</b>	<b>1,208,420</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			52,266	52,266		52,266		52,266		9
10	Nursing and Medical Records	2,263,424	104,450	159,340	2,527,214		2,527,214	(3,000)	2,524,214		10
10a	Therapy	119,431		3,210	122,641		122,641		122,641		10a
11	Activities	80,597	10,225	42	90,864		90,864		90,864		11
12	Social Services	144,633		3,155	147,788		147,788		147,788		12
13	CNA Training										13
14	Program Transportation			242	242		242		242		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,608,085</b>	<b>114,675</b>	<b>218,255</b>	<b>2,941,015</b>		<b>2,941,015</b>	<b>(3,000)</b>	<b>2,938,015</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	207,491		164,361	371,852		371,852	(76,197)	295,655		17
18	Directors Fees										18
19	Professional Services			432,291	432,291		432,291	(278,540)	153,751		19
20	Dues, Fees, Subscriptions & Promotions			76,274	76,274		76,274	(38,246)	38,028		20
21	Clerical & General Office Expenses	67,247	36,349	333,966	437,562		437,562	(229,953)	207,609		21
22	Employee Benefits & Payroll Taxes			555,862	555,862	27,816	583,678		583,678		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,965	2,965		2,965	270	3,235		24
25	Other Admin. Staff Transportation			1,316	1,316		1,316	(761)	555		25
26	Insurance-Prop.Liab.Malpractice			62,373	62,373		62,373	160,666	223,039		26
27	Other (specify):*							50,650	50,650		27
28	<b>TOTAL General Administration</b>	<b>274,738</b>	<b>36,349</b>	<b>1,629,408</b>	<b>1,940,495</b>	<b>27,816</b>	<b>1,968,311</b>	<b>(412,111)</b>	<b>1,556,200</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,500,391</b>	<b>534,036</b>	<b>2,076,275</b>	<b>6,110,702</b>		<b>6,110,702</b>	<b>(408,066)</b>	<b>5,702,636</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: 01/01/08 Ending: 12/31/08

## 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			13,533	13,533	13,533	241,749	255,282			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			19,840	19,840	19,840	285,962	305,802			32
33	Real Estate Taxes			1,125	1,125	1,125	55,204	56,329			33
34	Rent-Facility & Grounds			600,000	600,000	600,000	(600,000)				34
35	Rent-Equipment & Vehicles			9,484	9,484	9,484	(8,070)	1,414			35
36	Other (specify):*						26,104	26,104			36
37	<b>TOTAL Ownership</b>			643,982	643,982	643,982	949	644,931			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		259,665	587,808	847,473	847,473		847,473			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			85,644	85,644	85,644		85,644			42
43	Other (specify):*	153,907		58,543	212,450	212,450	(212,450)				43
44	<b>TOTAL Special Cost Centers</b>	153,907	259,665	731,995	1,145,567	1,145,567	(212,450)	933,117			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,654,298	793,701	3,452,252	7,900,251	7,900,251	(619,567)	7,280,684			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: 01/01/08

Ending: 12/31/08

**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	(3,005)	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	131,657	30		9
10	Interest and Other Investment Income	(13,213)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	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	(765)	21		18
19	Entertainment				19
20	Contributions	(10,743)	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	(308,366)	21		24
25	Fund Raising, Advertising and Promotional	(22,560)	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	(269,999)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (497,007)		\$	30

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)	(122,561)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (122,561)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (619,567)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	COPE Dues	\$ (5,693)	20	1
2	Marketing Salary	(153,907)	43	2
3	Marketing Consultant	(58,543)	43	3
4	Non-Allowable Auto Lease	(8,309)	35	4
5	Prior Period Adjustment- Nursing Expense	(3,000)	10	5
6	Prior Period Adjustment- Insurance Expense	(6,505)	26	6
7	Board of Elections Income	(525)	21	7
8	Non-Allowable Travel	(771)	25	8
9	Non-Allowable Seminar	(95)	24	9
10	Building Company- Annual Report	(100)	20	10
11	Building Company- Accounting Fees	(11,100)	19	11
12	Building Company- Amortization	(1,598)	36	12
13	Non-Allowable Legal Fees	(13,299)	19	13
14	Non-Allowable Accounting Fees	(5,000)	19	14
15	Non-Allowable Office Expense	(1,554)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(269,999)		49

Mayfield Care Center

ID# 0029660

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mayfield Care Center# 0029660

Report Period Beginning:

01/01/08

Ending:

12/31/08**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	(13)											(13)	2
3	Housekeeping			811		446							1,257	3
4	Laundry													4
5	Heat and Other Utilities			1,432		1,617							3,049	5
6	Maintenance	(3,005)		5,080		676							2,751	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(3,018)</b>		<b>7,323</b>		<b>2,739</b>							<b>7,044</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(3,000)											(3,000)	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>(3,000)</b>											<b>(3,000)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			76,373	(153,126)	556							(76,197)	17
18	Directors Fees													18
19	Professional Services	(29,399)	11,100	(260,449)		208							(278,540)	19
20	Fees, Subscriptions & Promotions	(39,096)	100	662	58	30							(38,246)	20
21	Clerical & General Office Expenses	(311,210)		81,164	56	37							(229,953)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(95)		365									270	24
25	Other Admin. Staff Transportation	(771)		10									(761)	25
26	Insurance-Prop.Liab.Malpractice	(6,505)	166,575	426		170							160,666	26
27	Other (specify):*			49,726	924								50,650	27
28	<b>TOTAL General Administration</b>	<b>(387,076)</b>	<b>177,775</b>	<b>(51,723)</b>	<b>(152,088)</b>	<b>1,001</b>							<b>(412,111)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(393,094)</b>	<b>177,775</b>	<b>(44,400)</b>	<b>(152,088)</b>	<b>3,740</b>							<b>(408,066)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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	131,657	104,465	5,325	44	258							241,749	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,213)	296,508	128		2,539							285,962	32
33	Real Estate Taxes		52,999			2,205							55,204	33
34	Rent-Facility & Grounds		(600,000)	12,167		(12,167)							(600,000)	34
35	Rent-Equipment & Vehicles	(8,309)		239									(8,070)	35
36	Other (specify):*	(1,598)	27,702										26,104	36
37	<b>TOTAL Ownership</b>	<b>108,537</b>	<b>(118,326)</b>	<b>17,859</b>	<b>44</b>	<b>(7,165)</b>							<b>949</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):*	(212,450)											(212,450)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(212,450)</b>											<b>(212,450)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(497,007)</b>	<b>59,449</b>	<b>(26,541)</b>	<b>(152,044)</b>	<b>(3,425)</b>							<b>(619,567)</b>	<b>45</b>

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 600,000	Mayfield Building Limited	100.00%	\$	\$ (600,000)	1
2	V	32 Interest Income	961	Mayfield Building Limited	100.00%		(961)	2
3	V	32 Interest Expense		Mayfield Building Limited	100.00%	297,469	297,469	3
4	V	36 Mortgage Insurance		Mayfield Building Limited	100.00%	26,104	26,104	4
5	V	26 Insurance		Mayfield Building Limited	100.00%	166,575	166,575	5
6	V	20 Annual Report Fees		Mayfield Building Limited	100.00%	100	100	6
7	V	19 Accounting Fees		Mayfield Building Limited	100.00%	11,100	11,100	7
8	V	30 Depreciation		Mayfield Building Limited	100.00%	104,465	104,465	8
9	V	36 Amortization		Mayfield Building Limited	100.00%	1,598	1,598	9
10	V	33 Real Estate Taxes		Mayfield Building Limited	100.00%	52,999	52,999	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 600,961			\$ 660,410	\$ * 59,449	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: 01/01/08 Ending: 12/31/08

## 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%	\$ 811	\$ 811	15
16	V	5 UTILITIES		MANAGCARE, INC.	100.00%	1,432	1,432	16
17	V	6 REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,080	5,080	17
18	V	10 NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17 ADMINISTRATIVE		MANAGCARE, INC.	100.00%	76,373	76,373	19
20	V	19 PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,067	1,067	20
21	V	20 FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	662	662	21
22	V	21 CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	81,164	81,164	22
23	V	24 SEMINARS		MANAGCARE, INC.	100.00%	365	365	23
24	V	25 ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	10	10	24
25	V	26 INSURANCE		MANAGCARE, INC.	100.00%	426	426	25
26	V	27 GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	49,726	49,726	26
27	V	30 DEPRECIATION		MANAGCARE, INC.	100.00%	5,325	5,325	27
28	V	32 INTEREST EXPENSE		MANAGCARE, INC.	100.00%	128	128	28
29	V	34 RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	12,167	12,167	29
30	V	35 EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	239	239	30
31	V	19 HOME OFFICE- BOOKKEEPING	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			\$ 234,975	\$ * (26,541)	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: 01/01/08 Ending: 12/31/08

## 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%	\$ 11,235	\$ 11,235	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%			16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	58	58	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	56	56	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	924	924	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	44	44	20
21	V								21
22	V	17	MANAGEMENT FEES	164,361	INTERCARE, LTD. C/O MANAGCARE	100.00%		(164,361)	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			\$ 164,361			\$ 12,317	\$ * (152,044)	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: 01/01/08 Ending: 12/31/08

## 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%	\$ 446	\$ 446	15
16	V	5 UTILITIES		MAZEL MANAGEMENT		1,617	1,617	16
17	V	6 REPAIRS & MAINT.		MAZEL MANAGEMENT		676	676	17
18	V	7 EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT				18
19	V	17 ADMIN.-M. WOLF		MAZEL MANAGEMENT		556	556	19
20	V	19 PROFESSIONAL FEES		MAZEL MANAGEMENT		208	208	20
21	V	20 FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		30	30	21
22	V	21 CLERICAL & GENERAL		MAZEL MANAGEMENT		37	37	22
23	V	26 INSURANCE		MAZEL MANAGEMENT		170	170	23
24	V	30 DEPRECIATION		MAZEL MANAGEMENT		258	258	24
25	V	31 AMORTIZATION		MAZEL MANAGEMENT				25
26	V	32 INTEREST EXPENSE		MAZEL MANAGEMENT		2,539	2,539	26
27	V	33 REAL ESTATE TAXES				2,205	2,205	27
28	V							28
29	V	34 RENT	12,167				(12,167)	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		\$ 12,167			\$ 8,742	\$ * (3,425)	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.

**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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Shareholder	Mgmt/Admin	69.38%	See Attached	4.27	12.56%	Sal./Al.Sal	\$ 26,235	17-1, 17-7	1
2	Renee Wolf	Relative	Clerical	0.00%	See Attached	2.13	23.67%	Alloc. Salary	950	17-7	2
3	Moshe Wolf	Relative	Administrative	0.00%	See Attached	9.49	23.73%	Alloc.Sal/Fees	20,694	17-7	3
4	Ronnie O'Connell	Shareholder	Administrative	1.34%	See Attached	9.49	22.60%	Alloc. Salary	26,227	17-7	4
5	Moshe Davis	Shareholder	Mgmt/Admin	0.56%	See Attached	48.00	100.00%	Salary	191,964	17-1	5
6	Yehoshua Davis	Shareholder	Administrative	0.56%	See Attached	-	-	Salary	527	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 266,597		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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	184,287	3	\$ 3,420	\$ 43,708	\$ 811	1
2	5	UTILITIES	PATIENT DAYS	184,287	3	6,039	43,708	1,432	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	184,287	3	21,421	43,708	5,080	3
4	10	NURSING SALARIES	PATIENT DAYS	184,287	3		43,708		4
5	17	ADMINISTRATIVE	PATIENT DAYS	184,287	3	322,013	322,013	76,373	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	184,287	3	4,498	43,708	1,067	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	184,287	3	2,792	43,708	662	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	184,287	3	342,215	291,331	81,164	8
9	24	SEMINARS	PATIENT DAYS	184,287	3	1,540	43,708	365	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	184,287	3	44	43,708	10	10
11	26	INSURANCE	PATIENT DAYS	184,287	3	1,796	43,708	426	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	184,287	3	209,662	43,708	49,726	12
13	30	DEPRECIATION	PATIENT DAYS	184,287	3	22,453	43,708	5,325	13
14	32	INTEREST EXPENSE	PATIENT DAYS	184,287	3	542	43,708	128	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	184,287	3	51,300	43,708	12,167	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	184,287	3	1,006	43,708	239	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 990,741	\$ 613,344		\$ 234,975	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 184,287	3	\$ 1,881	\$	43,708	\$ 446	1
2	5	UTILITIES	MNGCR. PATIENT DAYS 184,287	3	6,818		43,708	1,617	2
3	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS 184,287	3	2,848		43,708	676	3
4	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS 184,287	3			43,708		4
5	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS 184,287	3	2,343		43,708	556	5
6	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS 184,287	3	876		43,708	208	6
7	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS 184,287	3	125		43,708	30	7
8	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS 184,287	3	156		43,708	37	8
9	26	INSURANCE	MNGCR. PATIENT DAYS 184,287	3	717		43,708	170	9
10	30	DEPRECIATION	MNGCR. PATIENT DAYS 184,287	3	1,089		43,708	258	10
11	31	AMORTIZATION	MNGCR. PATIENT DAYS 184,287	3			43,708		11
12	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS 184,287	3	10,706		43,708	2,539	12
13	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS 184,287	3	9,299		43,708	2,205	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				\$ 36,858	\$		\$ 8,742	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	19	4	\$ 50,000	\$ 50,000	4	\$ 11,235	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	19	4			4		2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	19	4	256		4	58	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	19	4	251		4	56	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	19	4	4,113		4	924	5
6	30	DEPRECIATION	AVG. HOURS WORKED	19	4	197		4	44	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					\$ 54,817	\$ 50,000		\$ 12,317	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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	Greystone/Heartland		X					\$	5,233,342			\$	297,469	1						
2														2						
3														3						
4														4						
5	See Supplemental Schedule													5						
<b>Working Capital</b>																				
6	MB Financial Bank		X	Line of Credit					300,000				19,840	6						
7	Allocation From Mazel Mgmt		X										2,539	7						
8	See Supplemental Schedule												128	8						
9	<b>TOTAL Facility Related</b>							\$	5,533,342			\$	319,976	9						
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X										(13,213)	10						
11	Interest Income- Bldg Co.		X										(961)	11						
12														12						
13	See Supplemental Schedule													13						
14	<b>TOTAL Non-Facility Related</b>							\$				\$	(14,174)	14						
15	<b>TOTALS (line 9+line14)</b>							\$	5,533,342			\$	305,802	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 26,104      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:

01/01/08

Ending:

12/31/08

**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											
												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	Allocation From Managcare		X			\$	\$			\$	128										
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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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. <u>16-08-419-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,124.85</u>	\$ <u>1,124.85</u>
2. <u>16-08-419-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>12,141.36</u>	\$ <u>12,141.36</u>
3. <u>16-08-419-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>17,764.41</u>	\$ <u>17,764.41</u>
4. <u>16-08-419-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>12,308.11</u>	\$ <u>12,308.11</u>
5. <u>16-08-419-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,921.68</u>	\$ <u>8,921.68</u>
6. <u>16-08-419-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,463.39</u>	\$ <u>2,463.39</u>
7. <u>See Attached</u>	<u>Allocation From Managecare/Mazel</u>	\$ <u>51,704.53</u>	\$ <u>2,811.44</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>106,428.33</u>	\$ <u>57,535.24</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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>	\$ <u>_____</u>	\$ <u>_____</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?        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:

01/01/08 Ending:

12/31/08

**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

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	8,455	11
12	Various			1988	38,957		20	1,258	1,258	25,870	12
13	Various			1989	57,789		20	2,890	2,890	56,477	13
14	Various			1990	40,078		20	1,391	1,391	32,673	14
15	Various			1991	34,073		20	1,704	1,704	29,393	15
16	Various			1992	1,200		20	60	60	1,010	16
17	Various			1993	6,071		20	304	304	4,668	17
18	Various			1994	24,281		20	1,214	1,214	17,273	18
19	Various			1995	1,467		20	73	73	983	19
20	Various			1996	64,140		20	3,207	3,207	40,222	20
21	Various			1997	15,923		20	796	796	9,200	21
22	Various			1998	966,314		20	48,318	48,318	491,296	22
23	Various			1999	137,374		20	6,868	6,868	66,258	23
24	Various			2000	43,701		20	3,013	3,013	26,225	24
25	Various			2001	9,572		20	714	714	5,482	25
26	Various			2002	14,269		20	1,427	1,427	9,501	26
27	Various			2003	3,119		20	247	247	1,327	27
28	Various			2004	32,093		20	2,667	2,667	12,692	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:

01/01/08

Ending:

12/31/08

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	96,916		79,782	(17,134)	591,842	67
68		69,050	1,142		1,608	466	55,596	68
69			4,790			(4,790)		69
70		\$ 3,203,405	\$ 102,848		\$ 157,933	\$ 55,085	\$ 1,522,418	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,203,405	\$ 102,848		\$ 157,933	\$ 55,085	\$ 1,522,418	1
2	Detector Edges	2005	3,880		20	194	194	760	2
3	Fire Alarm System	2005	8,206		20	1,172	1,172	4,396	3
4	Hydraulic Packing	2005	2,500		20	125	125	469	4
5	A/C System Pump	2006	1,720		20	143	143	382	5
6	Detector Edge	2006	1,544		20	154	154	399	6
7	A/C Exv Valve/Repair	2006	3,683		20	307	307	767	7
8	Dome Ccd Camera	2006	1,216		20	243	243	506	8
9	Pyro Chem Fire System	2007	2,845		20	285	285	522	9
10	Monitoring System	2007	1,504		20	150	150	188	10
11	Color Dome Camera & Cctv	2007	1,933		20	193	193	274	11
12	Color Dome Camera	2007	1,699		20	170	170	297	12
13	Channel Color Multiplexor	2007	1,590		20	159	159	291	13
14	Cable Jacks	2007	9,840		20	984	984	1,640	14
15	Wiring - 75 Rooms	2007	8,502		20	850	850	1,700	15
16	Roofing	2007	1,875		20	188	188	297	16
17	2 Security Cameras	2007	3,036		20	304	304	506	17
18	Roofing	2007	3,200		20	320	320	533	18
19	Ductwork	2007	1,998		20	200	200	366	19
20	Wallcovering/Carpeting/Cove Base	2007	99,698		20	9,970	9,970	10,801	20
21	Closed Circuit Tv For 1St Floor Corridor	2008	1,086		20	100	100	100	21
22	Replace All Leaking Victaulic Seals On Elevators	2008	5,500		20	138	138	138	22
23	Brickwork	2008	18,800		20	940	940	940	23
24	New Concrete Slabs	2008	3,500		20	233	233	233	24
25	Metalwork	2008	1,440		20	84	84	84	25
26	120 Gallon Storage Tank	2008	4,483		20	187	187	187	26
27	Wallcovering/Cove Base/Handrails/Molding	2008	156,613		20	7,831	7,831	7,831	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

**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 12K, Carried Forward</b>		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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>		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

**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>		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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>		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

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		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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)		\$ 3,555,296	\$ 102,848		\$ 183,557	\$ 80,709	\$ 1,557,025	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:

01/01/08

Ending:

12/31/08

**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	\$ 96,916	20	\$ 79,782	\$ (17,134)	\$ 591,842	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

# 0029660

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	\$	96,916	\$	79,782	\$	(17,134)	\$	591,842	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Mayfield Care Center

# 0029660

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	Allocated From Mazel Management		1985	1985	\$ 24,469	\$	30	\$ 816	\$ 816	\$ 18,963	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated From Managcare			2008	3,317	829	20	304	(525)	304	9
10	Allocated From Managcare			1997	2,852	-	20	-		2,852	10
11	Allocated From Managcare			1993	224	-	20	11	11	174	11
12	Allocated From Managcare			1988	349	11	20	15	4	349	12
13	Allocated From Managcare			1986	26,462	-	20	-		26,461	13
14											14
15	Allocated From Intercare			2001	992	44	20	50	6	364	15
16											16
17	Allocated From Mazel Management			2007	1,440	37	20	72	35	111	17
18	Allocated From Mazel Management			2006	772	20	20	39	19	97	18
19	Allocated From Mazel Management			2005	577	72	20	58	(14)	201	19
20	Allocated From Mazel Management			2001	514	13	20	26	13	192	20
21	Allocated From Mazel Management			2000	260	7	20	13	6	107	21
22	Allocated From Mazel Management			1998	915	30	20	46	16	490	22
23	Allocated From Mazel Management			1997	854	22	20	43	21	484	23
24	Allocated From Mazel Management			1996	582	6	20	29	23	366	24
25	Allocated From Mazel Management			1995	132	3	20	7	4	89	25
26	Allocated From Mazel Management			1994	520	10	20	26	16	350	26
27	Allocated From Mazel Management			1993	307	9	20	15	6	237	27
28	Allocated From Mazel Management			1991	230	7	20	11	4	191	28
29	Allocated From Mazel Management			1990	357	7	20	18	11	328	29
30	Allocated From Mazel Management			1989	223	5	20	9	4	184	30
31	Allocated From Mazel Management			1987	508	10	20	-	(10)	508	31
32	Allocated From Mazel Management			1986	2,051	-	20	-		2,051	32
33	Allocated From Mazel Management			1985	143	-	20	-		143	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:

01/01/08

Ending:

12/31/08

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70	
			69,050		1,142		1,608	466	55,596

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: 01/01/08 Ending: 12/31/08

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	\$ 858,170	\$ 11,001	\$ 69,092	\$ 58,091	10	\$ 749,732	71
72	Current Year Purchases	11,196	6,436	819	(5,617)	10	819	72
73	Fully Depreciated Assets	220,886				10	220,834	73
74								74
75	TOTALS	\$ 1,090,252	\$ 17,437	\$ 69,911	\$ 52,474		\$ 971,385	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		Allocated From Managcare	2008	\$ 16,930	\$ 3,340	\$ 1,814	\$ (1,526)	5	\$ 8,011	76
77										77
78										78
79										79
80	TOTALS			\$ 16,930	\$ 3,340	\$ 1,814	\$ (1,526)		\$ 8,011	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)		\$ 4,831,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 123,625	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 255,282	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 131,657	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,536,421	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: 01/01/08

Ending: 12/31/08

**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.	<u>                    </u> /2009	\$ <u>                    </u>
13.	<u>                    </u> /2010	\$ <u>                    </u>
14.	<u>                    </u> /2011	\$ <u>                    </u>

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: \$ 1,414

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	\$		\$ 244,098	\$		\$ 244,098	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,865			80,865	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			262,481			262,481	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				131,993		131,993	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39 - 02					2,538		2,538	12
13	Other (specify): <u>See Supplemental</u>					364	125,134		125,498	13
14	<b>TOTAL</b>			\$		\$ 587,808	\$ 259,665		\$ 847,473	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: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 37,774	\$ 62,321	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,246,126	1,246,126	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,907	105,996	6
7	Other Prepaid Expenses	11,293	11,293	7
8	Accounts Receivable (owners or related parties)	974	974	8
9	Other(specify): <u>See Attached Schedule</u>	37,850	96,443	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,378,924	\$ 1,526,153	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,991	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	113,805	1,541,814	15
16	Equipment, at Historical Cost	112,818	1,231,812	16
17	Accumulated Depreciation (book methods)	(150,076)	(2,061,963)	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	1,086,907	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 82,642	\$ 3,668,209	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,461,566	\$ 5,194,362	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 959,898	\$ 970,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	224,565	224,565	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,244	15,244	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,700	32
33	Accrued Interest Payable	990	990	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	183,671	183,671	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,684,368	\$ 1,749,484	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,233,342	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>	\$	\$ 5,233,342	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,684,368	\$ 6,982,826	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (222,802)	\$ (1,788,464)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,461,566	\$ 5,194,362	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 264,750	1
2	Restatements (describe):		2
3	<b>Rounding Adjustment</b>	<b>9</b>	<b>3</b>
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 264,759	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(487,561)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (487,561)</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (222,802)</b>	<b>24 *</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center# 0029660Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 7,078,599	1
2	Discounts and Allowances for all Levels	(848,175)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,230,424	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	984,041	6
7	Oxygen	68	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 984,109	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	144,893	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,484	19
20	Radiology and X-Ray	915	20
21	Other Medical Services	23,959	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 182,251	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13,213	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 13,213	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,693	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,693	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,412,690	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,229,192	31
32	Health Care	2,941,015	32
33	General Administration	1,940,495	33
<b>B. Capital Expense</b>			
34	Ownership	643,982	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,059,923	35
36	Provider Participation Fee	85,644	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,900,251	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(487,561)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (487,561)	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:

01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,312	2,344	\$ 103,956	\$ 44.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,025	10,648	325,924	30.61	3
4	Licensed Practical Nurses	36,848	39,798	935,194	23.50	4
5	CNAs & Orderlies	75,066	82,801	845,129	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,188	8,218	119,431	14.53	8
9	Activity Director	1,912	2,168	28,617	13.20	9
10	Activity Assistants	5,635	6,012	51,980	8.65	10
11	Social Service Workers	7,733	8,484	144,633	17.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,831	21,935	227,244	10.36	15
16	Dishwashers					16
17	Maintenance Workers	6,540	7,055	65,619	9.30	17
18	Housekeepers	22,506	25,053	246,265	9.83	18
19	Laundry	7,410	8,416	78,440	9.32	19
20	Administrator	2,496	2,496	191,887	76.88	20
21	Assistant Administrator					21
22	Other Administrative	312	312	15,604	50.01	22
23	Office Manager					23
24	Clerical	4,025	4,337	67,247	15.51	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	3,752	4,214	53,221	12.63	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,721	4,721	153,907	32.60	33
34	TOTAL (lines 1 - 33)	218,312	239,012	\$ 3,654,298 *	\$ 15.29	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	307	\$ 13,355	01-03	35
36	Medical Director	Monthly	52,266	09-03	36
37	Medical Records Consultant	48	2,160	10-03	37
38	Nurse Consultant	156	12,922	10-03	38
39	Pharmacist Consultant	Monthly	3,180	10-03	39
40	Physical Therapy Consultant	25	1,470	10a-03	40
41	Occupational Therapy Consultant	16	930	10a-03	41
42	Respiratory Therapy Consultant	18	810	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	42	11-03	44
45	Social Service Consultant	57	3,155	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	628	\$ 90,290		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	241	\$ 11,051	10-03	50
51	Licensed Practical Nurses	3,894	130,027	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,135	\$ 141,078		53

SEE ACCOUNTANTS' COMPILATION REPORT



**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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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**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. IL Assoc. of HC \$1,872; ICLTC \$11,240
- (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. \$ 20,118 Line 10-02
- (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. \$ 85,644  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 27,816 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% Ln14
- 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