

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0054106</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Mado Healthcare Douglas Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1550 S Albany Avenue</u> <u>Chicago</u> <u>60623</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 277-6868</u> Fax # <u>(773) 277-5014</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>CAMILLE B. LOCKHART</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>CAMILLE B. LOCKHART</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>												
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	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>																								
Date of Initial License for Current Owners: <u>02/01/1971</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>PETER O'BRIEN</u> Telephone Number: <u>(312) 787-9400</u>																									
Email Address: _____																									

Facility Name & ID Number Mado Healthcare Douglas Park

0054106 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	172	Intermediate (ICF)	172	62,952	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,952	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	55,295	354	199	55,848	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,295	354	199	55,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.72%

D. How many bed reserve days during this year were paid by the Department? 264 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 7/1/1971

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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Mado Healthcare Douglas Park** # **0054106** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
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	
	A. General Services											
1	Dietary	362,799	38,513	18,895	420,207		420,207		420,207			1
2	Food Purchase		296,398		296,398	(35,568)	260,830	(6,926)	253,904			2
3	Housekeeping	245,280	77,534	28,529	351,343		351,343	(26,954)	324,389			3
4	Laundry	53,893	34,301		88,194		88,194		88,194			4
5	Heat and Other Utilities			134,950	134,950		134,950	(58,794)	76,156			5
6	Maintenance	152,368		122,107	274,475		274,475	(19,896)	254,579			6
7	Other (specify):*	478,827			478,827		478,827		478,827			7
8	TOTAL General Services	1,293,167	446,746	304,481	2,044,394	(35,568)	2,008,826	(112,570)	1,896,256			8
	B. Health Care and Programs											
9	Medical Director			14,817	14,817		14,817		14,817			9
10	Nursing and Medical Records	1,173,224	171,311	27,819	1,372,354		1,372,354	(100,285)	1,272,069			10
10a	Therapy											10a
11	Activities	219,461	21,221	29,150	269,832		269,832	(2,301)	267,531			11
12	Social Services	469,336	642	19,604	489,582		489,582		489,582			12
13	CNA Training											13
14	Program Transportation			2,754	2,754		2,754		2,754			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,862,021	193,174	94,144	2,149,339		2,149,339	(102,586)	2,046,753			16
	C. General Administration											
17	Administrative	54,588		959,072	1,013,660		1,013,660	(763,680)	249,980			17
18	Directors Fees											18
19	Professional Services			171,160	171,160		171,160	(3,450)	167,710			19
20	Dues, Fees, Subscriptions & Promotions			29,936	29,936		29,936	993	30,929			20
21	Clerical & General Office Expenses	168,946	27,454	70,478	266,878		266,878	355,763	622,641			21
22	Employee Benefits & Payroll Taxes			532,425	532,425	35,568	567,993		567,993			22
23	Inservice Training & Education			281	281		281		281			23
24	Travel and Seminar			564	564		564	(64)	500			24
25	Other Admin. Staff Transportation							840	840			25
26	Insurance-Prop.Liab.Malpractice			279,449	279,449		279,449	14,993	294,442			26
27	Other (specify):*							27,817	27,817			27
28	TOTAL General Administration	223,534	27,454	2,043,365	2,294,353	35,568	2,329,921	(366,788)	1,963,133			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,378,722	667,374	2,441,990	6,488,086		6,488,086	(581,944)	5,906,142			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			55,423	55,423		55,423	100,406	155,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,920	89,920		89,920	65,857	155,777			32
33	Real Estate Taxes							205,039	205,039			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(498,000)				34
35	Rent-Equipment & Vehicles			5,452	5,452		5,452		5,452			35
36	Other (specify):*			258	258		258	(166,000)	(165,742)			36
37	TOTAL Ownership			649,053	649,053		649,053	(292,698)	356,355			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,508		8,508		8,508		8,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		10,742		10,742		10,742	(10,742)				41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		19,250		19,250		19,250	(10,742)	8,508			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,378,722	686,624	3,091,043	7,156,389		7,156,389	(885,384)	6,271,005			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(48,325)	32		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	(9,340)	21		18
19	Entertainment	(64)	24		19
20	Contributions	(39,780)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,818)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(706)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(383,624)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (495,657)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(389,727)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (389,727)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (885,384)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (5,293)	21	1
2	BANK CHARGES	(3,112)	21	2
3	ACTIVITIES-CIGARETTES	(2,301)	11	3
4	CIGARETTE PURCHASES	(10,742)	41	4
5	R&M CAPITALIZED	(24,912)	6	5
6	ADJ TO S/L DEPR	81,181	30	6
7	COVID FUNDS-RENT	(166,000)	36	7
8	COVID FUNDS-UTILITIES	(59,432)	5	8
9	COVID FUNDS-NURSING SUPPLIES	(100,285)	10	9
10	COVID FUNDS-HSKP SUPPLIES	(26,954)	3	10
11	COVID FUNDS-KITCHEN SUPPLIES	(6,926)	2	11
12	COVID TAX CREDITS	(58,848)	27	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(383,624)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,926)	0	0	0	0	0	0	0	0	0	0	(6,926)	2
3	Housekeeping	(26,954)	0	0	0	0	0	0	0	0	0	0	(26,954)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(59,432)	0	638	0	0	0	0	0	0	0	0	(58,794)	5
6	Maintenance	(24,912)	0	5,016	0	0	0	0	0	0	0	0	(19,896)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(118,224)	0	5,654	0	0	0	0	0	0	0	0	(112,570)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(100,285)	0	0	0	0	0	0	0	0	0	0	(100,285)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,301)	0	0	0	0	0	0	0	0	0	0	(2,301)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(102,586)	0	0	0	0	0	0	0	0	0	0	(102,586)	16
	C. General Administration													
17	Administrative	0	0	(763,680)	0	0	0	0	0	0	0	0	(763,680)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,818)	0	10,368	0	0	0	0	0	0	0	0	(3,450)	19
20	Fees, Subscriptions & Promotions	0	0	993	0	0	0	0	0	0	0	0	993	20
21	Clerical & General Office Expenses	(58,231)	0	413,994	0	0	0	0	0	0	0	0	355,763	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(64)	0	0	0	0	0	0	0	0	0	0	(64)	24
25	Other Admin. Staff Transportation	0	0	840	0	0	0	0	0	0	0	0	840	25
26	Insurance-Prop.Liab.Malpractice	0	0	14,993	0	0	0	0	0	0	0	0	14,993	26
27	Other (specify):*	(58,848)	0	86,665	0	0	0	0	0	0	0	0	27,817	27
28	TOTAL General Administration	(130,961)	0	(235,827)	0	0	0	0	0	0	0	0	(366,788)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(351,771)	0	(230,173)	0	0	0	0	0	0	0	0	(581,944)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	81,181	0	19,225	0	0	0	0	0	0	0	0	100,406	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,325)	103,516	10,666	0	0	0	0	0	0	0	0	65,857	32
33	Real Estate Taxes	0	193,478	11,561	0	0	0	0	0	0	0	0	205,039	33
34	Rent-Facility & Grounds	0	(498,000)	0	0	0	0	0	0	0	0	0	(498,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(166,000)	0	0	0	0	0	0	0	0	0	0	(166,000)	36
37	TOTAL Ownership	(133,144)	(201,006)	41,452	0	0	0	0	0	0	0	0	(292,698)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(10,742)	0	0	0	0	0	0	0	0	0	0	(10,742)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(10,742)	0	0	0	0	0	0	0	0	0	0	(10,742)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(495,657)	(201,006)	(188,721)	0	0	0	0	0	0	0	0	(885,384)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	100	MADO HEALTHCARE - OLD TOWN	CHICAGO	Long Term Care LP	CHICAGO	REAL ESTATE
		MADO HEALTHCARE - BUENA PARK	CHICAGO	Mado Management	CHICAGO	BOOKKEEPING/M
		MADO HEALTHCARE - UPTOWN	CHICAGO	Mado LLC	CHICAGO	

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	Rent	\$ 498,000	Long Term Care LP	100.00%	\$	\$ (498,000)	1
2	V	32	Interest		Long Term Care LP	100.00%	103,516	103,516	2
3	V	33	Real Estate Tax		Long Term Care LP	100.00%	193,478	193,478	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 498,000			\$ 296,994	\$ * (201,006)	14

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

VII. RELATED PARTIES (continued)

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

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

1		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	5	Utilities	\$	Mado Management	100.00%	\$ 638	\$ 638	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	5,016	5,016	16
17	V	19	Professional Fees		Mado Management	100.00%	10,368	10,368	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	993	993	18
19	V	21	Clerical and General		Mado Management	100.00%	413,994	413,994	19
20	V	25	Auto Expense		Mado Management	100.00%	840	840	20
21	V	26	Insurance		Mado Management	100.00%	14,993	14,993	21
22	V	27	Employee Benefits		Mado Management	100.00%	57,828	57,828	22
23	V	30	Depreciation		Mado Management	100.00%	19,225	19,225	23
24	V	32	Interest		Mado Management	100.00%	10,666	10,666	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	11,561	11,561	25
26	V								26
27	V	17	Management Fees	828,000	Mado Management	100.00%		(828,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	64,320	64,320	29
30	V	27	Employee Benefits		Mado Management	100.00%	8,678	8,678	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%			32
33	V	27	Employee Benefits		Mado Management	100.00%	20,159	20,159	33
34	V								34
35	V	17	Administrative Salary	131,072	Mado Management	100.00%	131,072		35
36	V								36
37	V								37
38	V								38
39	Total			\$ 959,072			\$ 770,351	\$ * (188,721)	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	1	Dietary	\$ 18,895	MADO LLC	100.00%	\$ 18,895	\$	15
16	V	6	Maintenance	3,196			3,196		16
17	V	10	Nursing						17
18	V	11	Activities	868			868		18
19	V	12	Social Services	19,604			19,604		19
20	V	21	Office						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			\$ 42,563			\$ 42,563	\$ *	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.

YESNO

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			\$			\$0	\$*	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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			\$			\$0	\$*	39

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

VII. RELATED PARTIES (continued)

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

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

1		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			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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			\$			\$0	\$*	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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			\$			\$0	\$*	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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			\$			\$0	\$*	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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			\$			\$0	\$ *	39

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	PETER O'BRIEN	OWNER	ADMINISTRATIV	100.00	SEE ATTACHED	14.79	32.16	ALLOC SAL	\$ 64,320	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,320		13

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

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

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

MADO MANAGEMENT

Street Address

405 N WABASH UNIT P2W

City / State / Zip Code

CHICAGO, IL 60611

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	5	Utilities	Patient Days	173,633	4	\$ 1,984	\$	55,848	\$ 638	1
2	6	Repair & Maintenance	Patient Days	173,633	4	15,596		55,848	5,016	2
3	19	Professional Fees	Patient Days	173,633	4	32,235		55,848	10,368	3
4	20	Dues and Subscriptions	Patient Days	173,633	4	3,086		55,848	993	4
5	21	Clerical and General	Patient Days	173,633	4	1,287,117	1,242,587	55,848	413,994	5
6	25	Auto Expense	Patient Days	173,633	4	2,612		55,848	840	6
7	26	Insurance	Patient Days	173,633	4	46,614		55,848	14,993	7
8	27	Employee Benefits	Patient Days	173,633	4	179,790		55,848	57,828	8
9	30	Depreciation	Patient Days	173,633	4	59,771		55,848	19,225	9
10	32	Interest	Patient Days	173,633	4	33,160		55,848	10,666	10
11	33	Real Estate Taxes	Patient Days	173,633	4	35,943		55,848	11,561	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked			200,000	200,000		64,320	13
14	27	Employee Benefits	Avg Hrs Worked			26,984			8,678	14
15										15
16	17	Administrative Salary	Direct Allocation							16
17	27	Employee Benefits	Direct Allocation			74,027			20,159	17
18										18
19	17	Administrative Salary	Direct Allocation			428,308	428,308		131,072	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,427,227	\$ 1,870,895		\$ 770,351	25

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Mado Healthcare Douglas Park# 0054106

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10				
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	SIGNATURE BANK		X	MORTGAGE			\$	1,994,062			\$	103,516	1		
2	SIGNATURE BANK		X	PPP LOAN		4/16/20		680,300	680,300	4/16/22	1.0000		2		
3													3		
4													4		
5													5		
	Working Capital														
6	FIRST MIDWEST BANK		X	LINE OF CREDIT				511,668				58,238	6		
7	SIGNATURE		X	LINE OF CREDIT				96,571				31,682	7		
8													8		
9	TOTAL Facility Related						\$	680,300	\$	3,282,601			\$	193,436	9
	B. Non-Facility Related*														
10													10		
11	OFFSET INT INC											(48,325)	11		
12													12		
13	ALLOC FROM MADO MGT											10,666	13		
14	TOTAL Non-Facility Related						\$		\$				\$	(37,659)	14
15	TOTALS (line 9+line14)						\$	680,300	\$	3,282,601			\$	155,777	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	158,944	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	239,179	2
3. Under or (over) accrual (line 2 minus line 1).			\$	80,235	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	193,478	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	273,713	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	7,228	8	
		2016	228,738	9	
		2017	246,693	10	
		2018	223,768	11	
		2019	227,618	12	
Note: RE taxes paid includes \$11,561 alloc for Mado Management					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mado Healthcare Douglas Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054106

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

TELEPHONE (312) 787-9400 FAX #: (312) 787-9434

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-24-106-035		\$ 1,546.37	\$ 1,546.37
2. 16-24-106-036		\$ 2,968.93	\$ 2,968.93
3. 16-24-106-037		\$ 12,357.82	\$ 12,357.82
4. 16-24-106-032		\$ 57,215.10	\$ 57,215.10
5. 16-24-106-033		\$ 153,529.30	\$ 153,529.30
6. 17-04-204-012	Home Office (see attachment)	\$ 35,942.86	\$ 11,560.80
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 263,560.38	\$ 239,178.32

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mado Healthcare Douglas Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054106

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

A. Square Feet: 79,940

B. General Construction Type: Exterior Frame

Number of Stories 3

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).

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	FACILITY			\$ 22,077	1
2					2
3	TOTALS			\$ 22,077	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1971	1971	\$ 140,000	\$		\$		\$ 140,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1973		9,000		20			9,000	9
10	Various		1975		16,880		20			16,880	10
11	Various		1976		4,234		20			4,234	11
12	Various		1977		43,234		20			43,234	12
13	Various		1978		50,867		20			50,867	13
14	Various		1979		40,393		20			40,393	14
15	Various		1980		4,392		20			4,392	15
16	Various		1981		15,817		20			15,817	16
17	Various		1982		15,180		20			15,180	17
18	Various		1984		7,505		20			7,505	18
19	Various		1985		60,377		20			60,377	19
20	Various		1986		41,792		20			41,792	20
21	Various		1987		17,344		20			17,344	21
22	Various		1988		13,840		20			13,840	22
23	Various		1989		10,568		20			10,568	23
24	Various		1990		48,324		20			48,324	24
25	Various		1991		26,113		20			26,113	25
26	Various		1992		105,671		20			105,671	26
27	Various		1993		14,487		20			14,487	27
28	Various		1994		37,950		20			37,950	28
29	N'arious		1995		38,705		20			38,705	29
30	Various		1996		34,431		20			34,431	30
31	Various		1997		62,792		20			62,792	31
32	Various		1998		73,236		20			73,236	32
33	Various		1999		51,272		20			51,272	33
34	Various		2000		120,486		20	2,274	2,274	120,486	34
35	Various		2001		159,720		20	7,986	7,986	155,379	35
36	Various		2002		148,315		20			148,315	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	
37	Various	2003	\$ 140,910	\$	10	\$	\$	\$ 140,910	37
38	Various	2004	159,051		10			159,051	38
39	Various	2005	156,033		Various	9,221	9,221	142,149	39
40	Various	2006	173,699		Various			173,699	40
41	Various	2007	134,430		10			134,430	41
42	Various	2008	72,586		20	3,629	3,629	45,028	42
43	Pump Motor & Thermostatic Valve	2009	4,579		20	229	229	2,710	43
44	Removal & Repaving Of Courtyard	2009	7,000		20	350	350	4,054	44
45	New Layer Of Hot Roofing Rubber	2009	4,700		20	235	235	2,703	45
46	Doors For Resident Rooms	2009	3,352		20	168	168	1,917	46
47	Hot Water Heater & Installation Supplies	2009	4,564		20	228	228	2,604	47
48	Removal Of Fire Escape	2009	32,500		20	1,625	1,625	18,552	48
49	Brickwork For Doorways & Windows	2009	4,500		20	225	225	2,550	49
50	Closure Of 12 Fire Exit Doors	2009	5,056		20	253	253	2,867	50
51	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	147	147	1,642	51
52	Upgrade Boiler Room & Sewer	2009	2,548		20	127	127	1,419	52
53	Labor - Conversion Of Hobby Room To Activity Room	2009	5,355		20	268	268	2,970	53
54	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	802	802	8,889	54
55	2Nd & 3Rd Flr Bathrooms- Tiles, Shelves, Flushometer	2009	22,471		20	1,124	1,124	13,205	55
56	Coverion Of Hobby Room To Activiy Room- Flooring, Walls, Pai	2009	4,543		20	227	227	2,554	56
57	2Nd Flr Nurses Station& Activity Rm- Tiles, Paint, Ceiling	2009	16,020		20	801	801	8,878	57
58	2Nd Flr Nurses Station & Bathroom- Fixtures, Paint, Doors	2009	5,690		20	285	285	3,227	58
59	Install & Paint Iron Fence & Gate	2009	3,900		20	195	195	2,178	59
60	Upgrade 2Nd Floor Nurses Station- Flooring, Wall Work	2009	7,633		20	382	382	4,265	60
61	Upgrade Courtyard Gate	2009	2,754		20	138	138	1,529	61
62	Installation Of Exterior Lighting - Courtyard	2009	9,875		20	494	494	5,721	62
63	2Nd Flr Nurses Station- Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	731	731	8,102	63
64	2Nd & 3Rd Floor Security System - Cameras & Monitor	2010	4,872		20	244	244	2,642	64
65	Water Heater For Laundry	2010	4,162		10	314	314	4,162	65
66	Fire Alarm System Work	2010	3,400		20	170	170	1,728	66
67	Furnished And Installed Terrazzo Flooring	2010	4,300		20	215	215	2,365	67
68	Smoke Detectors & Fire Panels	2010	26,847		20	1,342	1,342	14,651	68
69	Fire Rated Doors	2010	10,594		20	530	530	5,785	69
70	TOTAL (lines 4 thru 69)		\$ 2,484,453	\$		\$ 34,959	\$ 34,959	\$ 2,337,717	70

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

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,484,453	\$		\$ 34,959	\$ 34,959	\$ 2,337,717	1
2	Conversion Of Activity Room To Rehab Office	2010	5,843		20	292	292	3,164	2
3	Window Screens	2010	4,239		20	212	212	2,297	3
4	Compressor For Fire Pump	2010	3,705		20	185	185	2,005	4
5	Furnished & Installed Pedestrian Door	2010	2,828		20	141	141	1,529	5
6	Furnished & Replaced Broken Section Of Boiler	2010	15,125		20	756	756	8,128	6
7	Electric Upgrade & Outlets For A/C	2010	28,750		20	1,438	1,438	15,337	7
8	New Central Heating & A/C Unit	2010	18,715		20	936	936	10,139	8
9	Doors & Supplies For 1St Floor Bathroom & Stairs	2010	3,611		20	181	181	1,914	9
10	1St Floor Bathrooms - Plumbing	2010	12,300		20	615	615	6,509	10
11	Electrical Work On 2Nd & 3Rd Floors	2010	2,875		20	144	144	1,511	11
12	Upgrade Fire Sprinkler System	2010	10,842		20	542	542	5,646	12
13	Floor Tiles - Iop Project	2010	7,981		20	399	399	4,123	13
14	Ceiling Tiles And Doors For Iop Office	2010	4,007		20	200	200	2,067	14
15	Electrical Work For Iop Office	2010	5,075		20	254	254	2,603	15
16	New Hvac For Iop Office	2010	6,220		20	311	311	3,188	16
17	Upgrade Electrical Panel	2010	4,587		20	229	229	2,348	17
18	Bathroom Renovation - Walls, Plumbing, Showers, Tubs, Lighting	2010	72,577		20	3,629	3,629	36,592	18
19	Iop Office Conversion - Demolition, Drywall, Electrical, Flooring,	2010	78,375		20	3,919	3,919	39,516	19
20	Iop Office Bathroom - Doors & Supplies	2010	3,492		20	175	175	1,807	20
21	Sprinkler Head Installations	2010	2,945		20	147	147	1,495	21
22	2Nd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	14,741		20	737	737	7,309	22
23	3Rd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	5,231		20	262	262	2,597	23
24	Janitor Closets - New Pipes, Walls, Tile, Sinks	2011	13,358		20	668	668	6,568	24
25	Reception & Conference Rm - Walls, Doors, Duct Work, Tile, Cab	2011	33,828		10	3,383	3,383	33,266	25
26	3Rd Floor Triage Unit - Walls, Floor, Electrical Fixtures, Doors, Si	2011	116,104		20	5,805	5,805	54,180	26
27	Fire Sprinklers - Elevator	2011	5,884		20	294	294	2,867	27
28	Fire Sprinklers - Reception & Lounge	2011	3,077		20	154	154	1,501	28
29	Additional Fire Sprinklers For State Compliance	2011	6,722		20	336	336	3,248	29
30	Fire Sprinklers - Janitor Closets	2011	3,716		20	186	186	1,798	30
31	Fire Sprinklers - Canopy	2011	2,708		20	135	135	1,306	31
32	New Windows	2011	6,924		20	346	346	3,258	32
33	Fire Sprinklers - Triage	2011	6,266		20	313	313	2,843	33
34	TOTAL (lines 1 thru 33)		\$ 2,997,104	\$		\$ 62,283	\$ 62,283	\$ 2,610,376	34

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

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,997,104	\$		\$ 62,283	\$ 62,283	\$ 2,610,376	1
2	Transitional Living Unit - Vents, Drains, Sewer Connect, Window	2011	89,875		20	4,494	4,494	44,565	2
3	Transitional Unit Construction Drawing & Permit	2011	13,959		20	698	698	6,398	3
4	Transitional Care Unit - Electrical Wiring	2012	32,285		Various	1,614	1,614	14,124	4
5	Transitional Care Unit - Fire Sprinkler System	2012	34,224		Various	1,711	1,711	14,686	5
6	Transitional Care Unit - Plumbing & Hvac	2012	10,014		Various	501	501	4,299	6
7	Transitional Care Unit - Labor & Materials	2012	98,849		Various	4,798	4,798	41,267	7
8	Transitional Care Unit - Doors	2012	9,580		27	355	355	3,305	8
9	Transitional Care Unit - Paint, Floor Tile, Adhesive Materials	2012	5,395		24	225	225	2,059	9
10	Transitional Care Unit - Fire Protection Windows	2012	4,285		Various	202	202	1,866	10
11	Transitional Care Unit - Additional Materials, Hvac, Lighting, Do	2012	39,920		Various	1,979	1,979	16,165	11
12	Water Heater	2012	9,865		Various	456	456	4,388	12
13	Granite Kitchen Top & Sink	2012	2,950		Various	141	141	1,251	13
14	Gas Pipes To Range Hood	2012	8,500		Various	411	411	3,571	14
15	Replace Hydraulic Valve	2012	2,638		20	132	132	1,181	15
16	Elevator Repair - Head Gaskets & Hydraulic Packing	2012	2,927		20	146	146	1,307	16
17	Roofing Work - South & Northwest Roof Of Bldg	2012	4,900		20	245	245	2,193	17
18	Addressable Fire Alarm System	2013	4,300		7	104	104	4,300	18
19	MATERIALS TO MAINTAIN 2ND FLOOR - ILP	2013	2,534		20	127	127	995	19
20	SUPPLIES FOR MAINTENANCE-ILP;TRIAGE,RESIDENTS' R	2013	2,639		20	132	132	990	20
21	MATERIALS FOR 2ND FLOOR; RESIDENTS' ROOM REPAIR	2013	2,759		20	138	138	1,092	21
22	FURNISHED & INSTALLED ONE NEW 230 VOLT IMPERIAL	2013	2,823		20	141	141	1,011	22
23	MATERIALS FOR 1ST FLOOR;BUILT 4 RESIDENTS BED&S	2013	3,440		20	172	172	1,276	23
24	BATTERIES, TILE CEILINGS, FLOOR TILES; ELECTRICAL	2013	4,747		20	237	237	1,699	24
25	MATERIALS TO MAINTAIN-COURTYARD,TRIAGE&AROU	2013	5,776		20	289	289	2,191	25
26	FURNITURE	2013	2,645		7			2,645	26
27	TEN(0) AIRCONDITIONERS 6000 BTU & TEN(10) UNTS 8MI	2013	3,592		5			3,591	27
28	FOUR(4) UNITS OF AIRCONDITIONERS	2013	7,097		5			7,097	28
29	ARMSTRONG PUMP	2014	1,305		10	131	131	906	29
30	ELECTRIC EYE PACKAGE FOR BACK DOOR	2014	1,158		10	116	116	783	30
31	SUPERVISORY ALARM PANEL	2014	3,900		10	390	390	2,633	31
32	IHP SNGL PAHSE AIR COMPRESSOR	2014	4,350		15	290	290	1,837	32
33	PAINTS AROUND THE BUILDING	2014	2,593		10	259	259	1,619	33
34	TOTAL (lines 1 thru 33)		\$ 3,422,928	\$		\$ 82,917	\$ 82,917	\$ 2,807,665	34

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

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,422,928	\$		\$ 82,917	\$ 82,917	\$ 2,807,665	1
2	REPAIRED FIRE SPRINKLER SYSTEM	2014	2,765		20	138	138	886	2
3	REPAIRED PASSENGER ELEVATOR	2014	3,334		20	167	167	1,085	3
4	ROOF IMPROVEMENT	2015	3,000		20	150	150	800	4
5	GAS FIRED STEAM BOILER	2015	57,554		20	2,878	2,878	15,109	5
6	MASONRY WORK TO 4 OPENINGS	2016	8,400		20	420	420	1,925	6
7	10 DUAL CATEGORY CABLED LOCATIONS	2016	3,095		20	155	155	684	7
8	FIRE SPRINKLER SYSTEM REPAIR	2016	10,344		20	517	517	2,284	8
9	WELDING-FIRE ESCAPE RAILING	2016	5,860		15	391	391	1,792	9
10	RADIATOR REPAIR & REPLACEMENT	2016	4,150		20	208	208	849	10
11	ROOF REPAIR	2017	29,000		20	1,450	1,450	4,592	11
12	ELEVATOR 1 REPAIR-NEW PUMP MOTORS & STARTER R	2017	6,417		20	321	321	1,230	12
13	ELEVATOR 1 REPAIR-REPLACEMENT OF VALVES	2017	9,476		20	474	474	1,698	13
14	HEATING UNITS REPAIR	2017	4,501		15	300	300	1,150	14
15	IRON FENCE	2017	2,700		15	180	180	660	15
16	8 RPZ BACKFLOWS-LABOR & MATERIALS	2018	6,900		20	345	345	719	16
17	REMODEL ROOMS-NEW DOORS, UPGRADE ELECTRICAL	2018	317,162		20	15,858	15,858	33,038	17
18	TILE REPLACED, PAINTED-ROOMS 308-315, 317, 321								18
19	203, 204, 208-215, 217-222								19
20	ELECTRICAL WORK-3rd FLOOR, 2nd FLOOR NORTH& SO	2018	11,070		20	554	554	1,385	20
21	NEW RADIATORS-ROOMS 309-315,317-318,320-321,	2018	31,850		25	1,274	1,274	2,654	21
22	ROOMS 201,204,209,211,214-15,217-18,220-221								22
23	21 A/C UNITS	2018	5,830		10	583	583	1,409	23
24	NEW A/C FOR EXISTING FURNACE	2018	3,000		10	300	300	700	24
25	KITCHEN HOOD EXHAUST FAN	2018	5,700		10	570	570	1,378	25
26	ELEVATOR REPAIR	2019	4,655		20	233	233	388	26
27	ELEVATOR REPAIR-REPLACE CAR SILL	2019	3,180		20	159	159	172	27
28	NEW CONDENSING UNIT-WALK IN FREEZER	2019	3,400		15	227	227	378	28
29	TUCKPOINT LIMESTONE PARAPET WALL - NORTH & EA	2019	5,700		20	285	285	451	29
30	WATER HEATER	2020	3,750		10	313	313	313	30
31	LAUNDRY ROOM RENOVATION-FLOORING/WALLS REPL	2020	77,455		20	2,259	2,259	2,259	31
32	ELEVATOR	2020	184,290		20	768	768	768	32
33	LAUNDRY ROOM WINDOWS	2020	3,750		10	219	219	219	33
34	TOTAL (lines 1 thru 33)		\$ 4,241,216	\$		\$ 114,613	\$ 114,613	\$ 2,888,639	34

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

XI. OWNERSHIP COSTS (continued)
 B. Building and Improvement Costs-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	
1 Totals from Page 12D, Carried Forward		\$ 4,241,216	\$		\$ 114,613	\$ 114,613	\$ 2,888,639	1
2								2
3								3
4 F/S Depreciation			54,938			(54,938)		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)		\$ 4,241,216	\$ 54,938		\$ 114,613	\$ 59,675	\$ 2,888,639	34

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

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,241,216	\$ 54,938		\$ 114,613	\$ 59,675	\$ 2,888,639	1
2	Related Party Information								2
3	Buildings:								3
4	MADO Management Allocation	2018	192,103	4,926	39	4,926		11,083	4
5									5
6									6
7									7
8									8
9	Leasehold Improvements:								9
10	MADO Management Allocation	2018	10,941	1,094	10	1,094		2,462	10
11	MADO Management Allocation	2018	4,339	217	20	217		489	11
12	MADO Management Allocation	2018	29,973	1,499	20	1,499		3,372	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)		\$ 4,478,572	\$ 62,674		\$ 122,349	\$ 59,675	\$ 2,906,045	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12F, Carried Forward		\$4,478,572	\$62,674		\$122,349	\$59,675	\$2,906,045	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,478,572	\$62,674		\$122,349	\$59,675	\$2,906,045	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,478,572	\$ 62,674		\$ 122,349	\$ 59,675	\$ 2,906,045	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,478,572	\$ 62,674		\$ 122,349	\$ 59,675	\$ 2,906,045	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,478,572	\$ 62,674		\$ 122,349	\$ 59,675	\$ 2,906,045	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,478,572	\$ 62,674		\$ 122,349	\$ 59,675	\$ 2,906,045	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$330,752	\$485	\$21,490	\$21,005		\$327,190	71
72	Current Year Purchases	21,162		501	501		501	72
73	Fully Depreciated Assets	219,567						73
74								74
75	TOTALS	\$571,481	\$485	\$21,991	\$21,506		\$327,691	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		1997 Jeep Grand Cherokee	1998	\$24,457	\$	\$	\$	5	\$
77		Allocated from MAD0 Management		80,608	11,489	11,489		5	59,905
78									
79									
80	TOTALS			\$105,065	\$11,489	\$11,489	\$		\$59,905

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$5,177,195	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$74,648	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$155,829	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$81,181	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$3,293,641	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 5,452 Description: Icemaker \$1,478; Copier \$3,974
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				7,288		7,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB	39-02					1,220		1,220	12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 8,508		\$ 8,508	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 346,667	\$	1
2	Cash-Patient Deposits	355,641		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(627,039)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,009		6
7	Other Prepaid Expenses	75		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Ex Account, Other</u>	124,975		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 225,328	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,999,841		15
16	Equipment, at Historical Cost	531,740		16
17	Accumulated Depreciation (book methods)	(2,195,569)		17
18	Deferred Charges	1,289		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(967)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	2,437,920		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,774,254	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,999,582	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 498,171	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,737		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	(30,387)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Insurance</u>	(28)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 642,701	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	996,804		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 996,804	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,639,505	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,360,077	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,999,582	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,564,142	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJ	(80,069)	3
4	ROUNDING	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,074	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	876,003	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 876,003	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,360,077	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,571,859	1
2	Discounts and Allowances for all Levels	(11,530)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,560,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,325	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48,325	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	5,293	28
28a	COVID RELATED INCOME	418,445	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 423,738	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,032,392	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,044,394	31
32	Health Care	2,149,339	32
33	General Administration	2,294,353	33
	B. Capital Expense		
34	Ownership	649,053	34
	C. Ancillary Expense		
35	Special Cost Centers	19,250	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,156,389	40
41	Income before Income Taxes (line 30 minus line 40)**	876,003	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 876,003	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,489,563	44
45	Private Pay - Net Inpatient Revenue	50,600	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) INSURANCE	69,650	47
48	Other-(specify) PRIOR YR ADJ/BAD DEBTS	(49,484)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,560,329	49

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

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

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

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

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	2,903	3,255	\$ 132,922	\$ 40.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,116	1,247	42,323	33.94	3
4	Licensed Practical Nurses	20,780	22,437	677,074	30.18	4
5	CNAs & Orderlies	18,510	20,130	313,326	15.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,510	2,669	50,414	18.89	9
10	Activity Assistants	10,424	11,432	169,047	14.79	10
11	Social Service Workers	22,259	25,274	469,336	18.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,416	22,243	362,799	16.31	15
16	Dishwashers					16
17	Maintenance Workers	8,070	8,774	152,368	17.37	17
18	Housekeepers	14,406	15,985	245,280	15.34	18
19	Laundry	3,065	3,707	53,893	14.54	19
20	Administrator					20
21	Assistant Administrator	2,025	2,131	54,588	25.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,746	10,601	168,946	15.94	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	406	536	7,579	14.14	31
32	Other Health Care(specify)					32
33	Other(specify)	27,932	30,226	478,827	15.84	33
34	TOTAL (lines 1 - 33)	164,568	180,647	\$ 3,378,722 *	\$ 18.70	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		\$		35
36	Medical Director	Monthly	14,817	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	164	11-03	44
45	Social Service Consultant			12-03	45
46	Other(specify)				46
47	Infectious Disease Consultant		1,600	10-03	47
48					48
49	TOTAL (lines 35 - 48)	3	\$ 17,781		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	298	13,427	10-03	51
52	Certified Nurse Assistants/Aides	485	11,592	10-03	52
53	TOTAL (lines 50 - 52)	783	\$ 25,019		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$
B. Administrative - Other			
Description			Amount
MANAGEMENT FEES		\$	828,000
ADMINISTRATOR - MADO			131,072
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 959,072
C. Professional Services			
Vendor/Payee	Type		Amount
ADELFLIA, LLC	ACCOUNTING	\$	7,400
BKD, LLP	ACCOUNTING		14,800
H2HHS, INC	MANAGEMENT CONS		58,670
PERSONNEL PLANNERS	UNEMP CONS		1,164
TERRENCE SULLIVAN CONS	STRATEGIC PLAN CONS		3,367
MAEMAR PC	ARCHITECT SERVICES		4,675
FMS LAW GROUP	LEGAL		4,785
BERGER, NEWMARK & FENCHEI	LEGAL		1,897
TED GIBBS ESQ	LEGAL		263
	LEGAL (NON ALLOW)		13,818
	DATA PROCESSING		60,321
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 171,160
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	99,202
Unemployment Compensation Insurance			18,507
FICA Taxes			251,071
Employee Health Insurance			150,941
Employee Meals			35,568
Illinois Municipal Retirement Fund (IMRF)*			
401K			4,901
MISC/TRAINING/INCENTIVES			8,717
PAYROLL TAX OVERPMT			(914)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 567,993
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)	9		336
Patient Background Checks	194		3,090
Advertising			
Licenses, Dues & Fees			26,510
MADO ALLOCATION			993
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 30,929
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			500
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	500

*** Attach copy of IMRF notifications**

****See instructions.**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>YES</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>10 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>4,325</u> Line <u>10-02</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>0</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation. _____</p> | <p>(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? <u>N/A</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>35,568</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>NO</u>
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>no</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? _____
 d. Have vehicle usage logs been maintained? <u>N/A</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
 g. Does the facility transport residents to and from day training? <u>NO</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. <u>YES</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|---|