

		FOR BHF USE					

LL1

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: 0054130

Facility Name: Mado Healthcare Old Town

Address: 1121 N Orleans St Chicago 60610
Number City Zip Code

County: Cook

Telephone Number: (312) 943-4300 Fax # (312) 943-4304

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1969

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: PETER O'BRIEN Telephone Number: (312) 787-9400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title) CAMILLE B. LOCKHART PARTNER

(Firm Name & Address) BKD, LLP P. O. BOX 1190, SPRINGFIELD, MO 65801-1190

(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Mado Healthcare Old Town

0054130 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	135	Intermediate (ICF)	135	49,410	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,410	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	41,684	31		41,715	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,684	31		41,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.43%

D. How many bed reserve days during this year were paid by the Department? 234 (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 07/01/1969

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

ACCUAL ☒ 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 Old Town** # **0054130** 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	322,001	48,401	18,895	389,297	(29,310)	359,987		359,987			1
2	Food Purchase		244,253		244,253		244,253	(11,294)	232,959			2
3	Housekeeping	153,151	60,431	9,722	223,304		223,304	(17,333)	205,971			3
4	Laundry	30,765	28,164		58,929		58,929		58,929			4
5	Heat and Other Utilities			77,282	77,282		77,282	(35,764)	41,518			5
6	Maintenance	80,026		74,136	154,162		154,162	48	154,210			6
7	Other (specify):*	226,739			226,739		226,739		226,739			7
8	TOTAL General Services	812,682	381,249	180,035	1,373,966	(29,310)	1,344,656	(64,343)	1,280,313			8
	B. Health Care and Programs											
9	Medical Director			14,350	14,350		14,350		14,350			9
10	Nursing and Medical Records	966,437	101,747	2,860	1,071,044		1,071,044	(67,508)	1,003,536			10
10a	Therapy											10a
11	Activities	78,947	35,525	19,277	133,749		133,749	(30)	133,719			11
12	Social Services	221,820	3,491	16,038	241,349		241,349	(5)	241,344			12
13	CNA Training											13
14	Program Transportation			3,549	3,549		3,549		3,549			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,267,204	140,763	56,074	1,464,041		1,464,041	(67,543)	1,396,498			16
	C. General Administration											
17	Administrative			740,148	740,148		740,148	(587,940)	152,208			17
18	Directors Fees											18
19	Professional Services			130,362	130,362		130,362	(6,078)	124,284			19
20	Dues, Fees, Subscriptions & Promotions			24,330	24,330		24,330	741	25,071			20
21	Clerical & General Office Expenses	63,716	21,711	31,948	117,375		117,375	279,365	396,740			21
22	Employee Benefits & Payroll Taxes			365,668	365,668	29,310	394,978		394,978			22
23	Inservice Training & Education			561	561		561		561			23
24	Travel and Seminar			808	808		808	(342)	466			24
25	Other Admin. Staff Transportation							628	628			25
26	Insurance-Prop.Liab.Malpractice			223,293	223,293		223,293	11,199	234,492			26
27	Other (specify):*							30,613	30,613			27
28	TOTAL General Administration	63,716	21,711	1,517,118	1,602,545	29,310	1,631,855	(271,814)	1,360,041			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,143,602	543,723	1,753,227	4,440,552		4,440,552	(403,700)	4,036,852			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			44,827	44,827		44,827	26,614	71,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,956	49,956		49,956	149,901	199,857			32
33	Real Estate Taxes							177,159	177,159			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			4,802	4,802		4,802		4,802			35
36	Other (specify):*			169	169		169	(266,000)	(265,831)			36
37	TOTAL Ownership			555,754	555,754		555,754	(368,326)	187,428			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,804		6,804		6,804		6,804			39
40	Barber and Beauty Shops			490	490		490		490			40
41	Coffee and Gift Shops		6,243		6,243		6,243	(6,243)				41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		13,047	490	13,537		13,537	(6,243)	7,294			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,143,602	556,770	2,309,471	5,009,843		5,009,843	(778,269)	4,231,574			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		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	(1,834)	21		18
19	Entertainment	(342)	24		19
20	Contributions	(11,900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,822)	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	(536)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(448,357)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (476,791)		\$	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)	(301,478)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (301,478)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (778,269)		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			Sch. V Line	
	Amount	Reference		
1	MISC INCOME	\$ (11,040)	21	1
2	BANK CHARGES	(2,756)	21	2
3	MISC-CLIENT CLOTHING	(1,796)	21	3
4	ACTIVITIES-CIGARETTES	(30)	11	4
5	SOCIAL SERVICES-CIGARETTES	(5)	12	5
6	CIGARETTES	(6,243)	41	6
7	R&M CAP IMPROVEMENTS	(3,700)	6	7
8	ADJ TO S/L DEPR	12,254	30	8
9	COVID FUNDS-RENT	(266,000)	36	9
10	COVID FUNDS-UTILITIES	(36,240)	5	10
11	COVID FUNDS-NURSING SUPPLIES	(67,508)	10	11
12	COVID FUNDS-HSKP SUPPLIES	(17,333)	3	12
13	COVID FUNDS-KITCHEN SUPPLIES	(11,294)	2	13
14	COVID TAX CREDITS	(36,666)	27	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(448,357)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mado Healthcare Old Town# 0054130

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	(11,294)	0	0	0	0	0	0	0	0	0	0	(11,294)	2
3	Housekeeping	(17,333)	0	0	0	0	0	0	0	0	0	0	(17,333)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(36,240)	0	476	0	0	0	0	0	0	0	0	(35,764)	5
6	Maintenance	(3,700)	0	3,748	0	0	0	0	0	0	0	0	48	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(68,567)	0	4,224	0	0	0	0	0	0	0	0	(64,343)	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	(67,508)	0	0	0	0	0	0	0	0	0	0	(67,508)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(30)	0	0	0	0	0	0	0	0	0	0	(30)	11
12	Social Services	(5)	0	0	0	0	0	0	0	0	0	0	(5)	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	(67,543)	0	0	0	0	0	0	0	0	0	0	(67,543)	16
	C. General Administration													
17	Administrative	0	0	(587,940)	0	0	0	0	0	0	0	0	(587,940)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,822)	0	7,744	0	0	0	0	0	0	0	0	(6,078)	19
20	Fees, Subscriptions & Promotions	0	0	741	0	0	0	0	0	0	0	0	741	20
21	Clerical & General Office Expenses	(29,862)	0	309,227	0	0	0	0	0	0	0	0	279,365	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	(342)	0	0	0	0	0	0	0	0	0	0	(342)	24
25	Other Admin. Staff Transportation	0	0	628	0	0	0	0	0	0	0	0	628	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,199	0	0	0	0	0	0	0	0	11,199	26
27	Other (specify):*	(36,666)	0	67,279	0	0	0	0	0	0	0	0	30,613	27
28	TOTAL General Administration	(80,692)	0	(191,122)	0	0	0	0	0	0	0	0	(271,814)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(216,802)	0	(186,898)	0	0	0	0	0	0	0	0	(403,700)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mado Healthcare Old Town # 0054130 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	12,254	0	14,360	0	0	0	0	0	0	0	0	26,614	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	141,934	7,967	0	0	0	0	0	0	0	0	149,901	32
33	Real Estate Taxes	0	168,524	8,635	0	0	0	0	0	0	0	0	177,159	33
34	Rent-Facility & Grounds	0	(456,000)	0	0	0	0	0	0	0	0	0	(456,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(266,000)	0	0	0	0	0	0	0	0	0	0	(266,000)	36
37	TOTAL Ownership	(253,746)	(145,542)	30,962	0	0	0	0	0	0	0	0	(368,326)	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	(6,243)	0	0	0	0	0	0	0	0	0	0	(6,243)	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	(6,243)	0	0	0	0	0	0	0	0	0	0	(6,243)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(476,791)	(145,542)	(155,936)	0	0	0	0	0	0	0	0	(778,269)	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 - UPTOWN	CHICAGO	Long Term Care LP	CHICAGO	REAL ESTATE
		MADO HEALTHCARE - BUENA PARK	CHICAGO	Mado Management	CHICAGO	BOOKKEEPING/M
		MADO HEALTHCARE - DOUGLAS PARK	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	Rental Income	\$ 456,000	Long Term Care LP	100.00%	\$	(456,000)	1
2	V	32	Interest		Long Term Care LP	100.00%	141,934	141,934	2
3	V	33	Real Estate Taxes		Long Term Care LP	100.00%	168,524	168,524	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			\$ 456,000			\$ 310,458	\$ * (145,542)	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%	\$ 476	\$ 476	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	3,748	3,748	16
17	V	19	Professional Fees		Mado Management	100.00%	7,744	7,744	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	741	741	18
19	V	21	Clerical and General		Mado Management	100.00%	309,227	309,227	19
20	V	25	Auto Expense		Mado Management	100.00%	628	628	20
21	V	26	Insurance		Mado Management	100.00%	11,199	11,199	21
22	V	27	Employee Benefits		Mado Management	100.00%	43,195	43,195	22
23	V	30	Depreciation		Mado Management	100.00%	14,360	14,360	23
24	V	32	Interest		Mado Management	100.00%	7,967	7,967	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	8,635	8,635	25
26	V								26
27	V	17	Management Fees	636,000	Mado Management	100.00%		(636,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	48,060	48,060	29
30	V	27	Employee Benefits		Mado Management	100.00%	6,484	6,484	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%			32
33	V	27	Employee Benefits		Mado Management	100.00%	17,600	17,600	33
34	V								34
35	V	17	Administrative Salary	104,148	Mado Management	100.00%	104,148		35
36	V								36
37	V								37
38	V								38
39	Total			\$ 740,148			\$ 584,212	\$ * (155,936)	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						16
17	V	10	Nursing						17
18	V	11	Activities	18,923			18,923		18
19	V	12	Social Services	16,038			16,038		19
20	V	21	Office	1,478			1,478		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			\$ 55,334			\$ 55,334	\$ *	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.

☐ 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 Old Town # 0054130 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	11.05	24.03	ALLOC SAL	\$ 48,060	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	\$ 48,060		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 Old Town# 0054130

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	173,633	4	\$ 1,984	\$	41,715	\$ 476	1
2	6	Repair & Maintenance	Patient Days	173,633	4	15,596		41,715	3,748	2
3	19	Professional Fees	Patient Days	173,633	4	32,235		41,715	7,744	3
4	20	Dues and Subscriptions	Patient Days	173,633	4	3,086		41,715	741	4
5	21	Clerical and General	Patient Days	173,633	4	1,287,117	1,242,587	41,715	309,227	5
6	25	Auto Expense	Patient Days	173,633	4	2,612		41,715	628	6
7	26	Insurance	Patient Days	173,633	4	46,614		41,715	11,199	7
8	27	Employee Benefits	Patient Days	173,633	4	179,790		41,715	43,195	8
9	30	Depreciation	Patient Days	173,633	4	59,771		41,715	14,360	9
10	32	Interest	Patient Days	173,633	4	33,160		41,715	7,967	10
11	33	Real Estate Taxes	Patient Days	173,633	4	35,943		41,715	8,635	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked			200,000	200,000		48,060	13
14	27	Employee Benefits	Avg Hrs Worked			26,984			6,484	14
15										15
16	17	Administrative Salary	Direct Allocation							16
17	27	Employee Benefits	Direct Allocation			74,027			17,600	17
18										18
19	17	Administrative Salary	Direct Allocation			428,308	428,308		104,148	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,427,227	\$ 1,870,895		\$ 584,212	25

Facility Name & ID Number Mado Healthcare Old Town # 0054130 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 Old Town# 0054130

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 Old Town# 0054130

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 Old Town # 0054130 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 Old Town # 0054130 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 Old Town # 0054130 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 Old Town# 0054130

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 Old Town# 0054130

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 Old Town # 0054130 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			\$	2,583,534			\$	141,934	1		
2	SIGNATURE BANK		X	PPP LOAN		4/16/20		448,400	448,400	4/16/22	1.0000		2		
3													3		
4													4		
5													5		
	Working Capital														
6	FIRST MIDWEST BANK		X	LINE OF CREDIT				127,217				22,183	6		
7	SIGNATURE BANK		X	LINE OF CREDIT				56,623				27,823	7		
8													8		
9	TOTAL Facility Related						\$	448,400	\$	3,215,774			\$	191,940	9
	B. Non-Facility Related*														
10	Nonallowable												10		
11	REFUND											(50)	11		
12	Allowable:												12		
13	ALLOC FROM MADO MGT											7,967	13		
14	TOTAL Non-Facility Related						\$		\$				\$	7,917	14
15	TOTALS (line 9+line14)						\$	448,400	\$	3,215,774			\$	199,857	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.		\$	180,175	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.)				\$	180,278	2
3. Under or (over) accrual (line 2 minus line 1).				\$	103	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	168,523	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.				\$	168,626	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	139,313	8	FOR BHF USE ONLY	
		2016	152,270	9		
		2017	163,660	10		
		2018	168,756	11		
		2019	171,643	12		
Note: RE taxes paid includes \$8,635 alloc from HO				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 Old Town COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054130

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)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>17-04-401-001</u>	<u></u>	\$ <u>22,507.01</u>	\$ <u>22,507.01</u>
2. <u>17-04-401-004</u>	<u></u>	\$ <u>5,625.34</u>	\$ <u>5,625.34</u>
3. <u>17-04-401-005</u>	<u></u>	\$ <u>5,849.95</u>	\$ <u>5,849.95</u>
4. <u>17-04-401-006</u>	<u></u>	\$ <u>6,190.11</u>	\$ <u>6,190.11</u>
5. <u>17-04-401-007</u>	<u></u>	\$ <u>6,638.38</u>	\$ <u>6,638.38</u>
6. <u>17-04-401-008</u>	<u></u>	\$ <u>7,314.22</u>	\$ <u>7,314.22</u>
7. <u>17-04-401-009</u>	<u></u>	\$ <u>8,102.02</u>	\$ <u>8,102.02</u>
8. <u>17-04-401-010</u>	<u></u>	\$ <u>27,778.76</u>	\$ <u>27,778.76</u>
9. <u>17-04-409-009</u>	<u></u>	\$ <u>81,637.13</u>	\$ <u>81,637.13</u>
10. <u>17-04-204-012</u>	<u>Home Office(see attachment)</u>	\$ <u>35,942.86</u>	\$ <u>8,635.20</u>
TOTALS		\$ <u><u>207,585.78</u></u>	\$ <u><u>180,278.12</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 Old Town COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054130

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
Tax Index Number	Property Description	Total 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,250 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 5

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

NONE

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	26,250	1962	\$ 2,000	1
2					2
3	TOTALS	26,250		\$ 2,000	3

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1975		9,723		20			9,723	9
10	Various		1976		6,706		20			6,706	10
11	Various		1977		46,090		20			46,090	11
12	Various		1978		21,593		20			21,593	12
13	Various		1979		23,565		20			23,565	13
14	Various		1982		4,014		20			3,981	14
15	Various		1983		5,200		20			5,200	15
16	Various		1984		4,952		20			4,344	16
17	Various		1985		9,766		20			9,548	17
18	Various		1986		36,773		20			30,774	18
19	Various		1987		7,315		20			7,315	19
20	Various		1988		6,455		20			6,455	20
21	Various		1989		2,400		20			2,400	21
22	Various		1990		7,500		20			6,209	22
23	Various		1991		19,058		20			19,058	23
24	Various		1992		103,932		20			103,932	24
25	Various - removed \$3,565 per 2015 capital cost adj audit. Remvd. \$11,000		1993		50,916		20			50,916	25
26	Various		1994		115,474		20			115,474	26
27	Various		1995		17,694		20			17,694	27
28	Various - removed \$22,987 per 2015 capital cost adj audit		1996		67,919		20			67,919	28
29	Various - removed \$6,643 per capital cost adj audit		1997		84,459		20			84,459	29
30	Various - - removed \$2,470 & \$1,800 per 2015 capital cost adj audit		1998		69,815		20			69,815	30
31	Various - removed \$1,743 per 2015 capital cost adj audit		1999		20,326		20			20,308	31
32	Various		2000		53,714		20	997	997	53,714	32
33	Various - removed \$798, \$36,620 & \$940 per capital cost adj audit		2001		130,073		20	2,686	2,686	112,444	33
34	Various - removed \$3,593 per 2015 capital cost adj audit		2002		140,335		20			140,335	34
35	Various - removed \$593 & \$1,216 per capital cost adj audit		2003		72,824		20	3,641	3,641	62,802	35
36	Various		2004		137,143		20			137,143	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 Old Town

0054130

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	
37	Various	2005	\$ 135,532	\$	20	\$ 6,777	\$ 6,777	\$ 118,644	37
38	Various	2006	124,264		20			124,264	38
39	Various	2007	37,298		20			37,298	39
40	Various - removed \$1,421 disposal per client	2008	129,190		20	6,460	6,460	80,989	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,702,018	\$		\$ 20,561	\$ 20,561	\$ 1,601,109	70

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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		\$ 1,702,018	\$		\$ 20,561	\$ 20,561	\$ 1,601,109	1
2	Gas Water Heater	2009	4,292		20	215	215	2,400	2
3	Grind Out Old Mortar	2009	72,900		20	3,645	3,645	43,740	3
4	Flooring & Shower Bases	2009	7,800		20	390	390	4,648	4
5	Resident Room Flooring	2009	5,154		20	258	258	3,009	5
6	2 Vacuum Condensate Tanks	2009	9,885		20	494	494	5,517	6
7	Asphalt Repairs	2010	4,427		20	221	221	2,487	7
8	Activity Room	2010	2,515		20	126	126	1,354	8
9	Intercom System Upgrade	2010	9,860		20	493	493	5,094	9
10	Install Fire Pump	2010	3,765		20	188	188	2,069	10
11	Elevator Motor Repair -changed year from 2011 to 2010 per 2015	2010	10,356		20	518	518	5,611	11
12	Hot Water Heater in Laundry Room	2011	4,677		20	234	234	2,301	12
13	Smoke Detectors-Resident Rooms	2011	12,900		20	645	645	6,450	13
14	Refurbished Gear Boxe for Elevator Machine	2011	10,280		20	514	514	4,840	14
15	Replacement of 33 Sprinkler Heads	2011	3,866		20	193	193	1,802	15
16	Tuckpointing of Roof-SW & ES Walls	2012	9,100		20	455	455	4,095	16
17	Furnished & Installed Pit Safety Switch & Wire - removed \$2,514	2012							17
18	Stone Retaining Wall-East Courtyard	2013	4,800		20	240	240	1,920	18
19	First Floor Kitchen;Lobby;Hallway - New Fire Sprinklers and Sm	2013	12,870		20	644	644	5,200	19
20	Elevator Gate Operator	2013	3,659		20	183	183	1,464	20
21	Repaired Main Sewer Line	2013	3,600		20	180	180	1,440	21
22	First Floor - Addt'l Lintel Door Openings	2013	1,050		20	53	53	423	22
23	First Floor Bathroom, Kitchen & Living Area Materials for -	2013							23
24	Plumbing, Electrical, Flooring and Painting-removed \$1,901 per 2	2013	26,982		20	1,349	1,349	10,982	24
25	First Floor - Labor for Demolition; Plumbing;Electrical;Tiling & 1	2013	25,675		20	1,284	1,284	10,272	25
26	NRSg office, conf room, dev office (2)-replace all woodwork,	2014	19,949		20	997	997	6,979	26
27	new electrical wiring & fixtures; painting	2014							27
28	Supervisory/tamper switch fire alarm	2014	16,015		20	801	801	5,607	28
29	Repair fire sprinkler	2014	2,852		20	143	143	965	29
30	AP Heating System-stem radiators-bathroom, dining, kitchen & li	2015	6,900		20	345	345	1,984	30
31	Boiler-supply & install boiler - removed rebate of \$6,824 per 2015	2015	38,006		20	1,900	1,900	10,925	31
32	Fire Sprinkler Repairs	2015	11,419		20	571	571	3,331	32
33	Electrical upgrades to Vault Room	2016	17,389		20	869	869	4,055	33
34	TOTAL (lines 1 thru 33)		\$ 2,064,961	\$		\$ 38,709	\$ 38,709	\$ 1,762,073	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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		\$ 2,064,961	\$		\$ 38,709	\$ 38,709	\$ 1,762,073	1
2	Fire Troll Fire Pump Controller	2016	11,000		20	550	550	2,429	2
3	Roof-new aluminum ridge cap over Chapel	2016	2,550		10	255	255	1,190	3
4	Condensing Unit	2017	6,600		15	440	440	1,760	4
5	Tuckpointing, detailing & painting outside bricks	2017	16,500		20	825	825	3,094	5
6	Fence Wall tuckpointing, repair & power washing	2017	4,500		25	180	180	615	6
7	Replace Sprinkler Heads	2017	13,830		20	692	692	2,652	7
8	Fire Pump Repair	2017	3,000		20	150	150	575	8
9	Fire Sprinkler System Repair	2017	4,135		20	207	207	759	9
10	Repair rodding main sewer kitchen to street-labor & materials	2018	2,800		20	140	140	408	10
11	6 RPZ Backflows-labor & materials	2018	4,800		20	240	240	480	11
12	Iron Fence Installation	2019	3,700		15	247	247	350	12
13	3 A/C Units & new wiring	2019	2,595		10	260	260	368	13
14	Roof Repair	2019	4,700		20	235	235	294	14
15	Rooms 209 & 309: removed old wall, floors & ceilings	2019	2,895		20	145	145	145	15
16	Room 409 renovation-radiators,flooring, new doors,drywall-labor	2020	27,017		20	1,126	1,126	1,126	16
17	Radiators	2020	3,700		20	170	170	170	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	F/S Depreciation			39,797			(39,797)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,179,283	\$ 39,797		\$ 44,571	\$ 4,774	\$ 1,778,488	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 12C, Carried Forward		\$ 2,179,283	\$ 39,797		\$ 44,571	\$ 4,774	\$ 1,778,488	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	2018	143,489	3,679	39	3,679		8,278	4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management	2018	8,172	817	10	817		1,839	9
10	Allocated from Mado Management	2018	3,241	162	20	162		365	10
11	Allocated from Mado Management	2018	22,388	1,119	20	1,119		2,519	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	Rounding			1		1		1	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 12D, Carried Forward		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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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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)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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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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)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 12F, Carried Forward		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 12G, Carried Forward		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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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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)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	34

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

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 12H, Carried Forward		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,356,573	\$ 45,575		\$ 50,349	\$ 4,774	\$ 1,791,490	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	\$ 158,247	\$ 470	\$ 10,092	\$ 9,622		\$ 149,456	71
72	Current Year Purchases	4,560	4,560	25	(4,535)		76	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 162,807	\$ 5,030	\$ 10,117	\$ 5,087		\$ 149,532	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		86 OLDS	1990	\$	\$	\$	\$		\$	76
77		Allocated from MADO Managem	Various	60,209	8,582	8,582		5	44,745	77
78		2011 TOYOTA SIENNA VAN	2019	9,571		2,393	2,393	4	3,191	78
79										79
80	TOTALS			\$ 69,780	\$ 8,582	\$ 10,975	\$ 2,393		\$ 47,936	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,591,160	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,441	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,254	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,988,958	85

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

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

G. Construction-in-Progress

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

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

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

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: \$4,802 Description: Ice maker \$1308; Copier \$3,494
(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

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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				4,953		4,953	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): LAB	39-02					1,851		1,851	12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 6,804		\$ 6,804	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	\$ 322,790	\$	1
2	Cash-Patient Deposits	192,216		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	(434,128)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,050		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Refund,Ex Acct, Deposits</u>	30,331		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 131,259	\$	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	2,036,619		15
16	Equipment, at Historical Cost	408,151		16
17	Accumulated Depreciation (book methods)	(1,673,847)		17
18	Deferred Charges	211		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	2,187,116		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,958,250	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,089,509	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 411,413	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,090		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,875		30
31	Accrued Taxes Payable (excluding real estate taxes)	(17,282)		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				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,096	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	632,240		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>CARES/PRF FUNDS</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 632,240	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,120,336	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,969,173	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,089,509	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,399,911	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,399,911	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	569,260	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) ROUNDING	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 569,262	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,969,173	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mado Healthcare Old Town

0054130

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	\$ 5,134,118	1
2	Discounts and Allowances for all Levels	(1,096)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,133,022	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC	11,040	28
28a	COVID FUNDS	435,041	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 446,081	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,579,103	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,373,966	31
32	Health Care	1,464,041	32
33	General Administration	1,602,545	33
	B. Capital Expense		
34	Ownership	555,754	34
	C. Ancillary Expense		
35	Special Cost Centers	13,537	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)*	\$ 5,009,843	40
41	Income before Income Taxes (line 30 minus line 40)**	569,260	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 569,260	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,135,365	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PRIOR YR ADJ/BAD DEBTS	(2,343)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,133,022	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	2,323	2,484	\$ 89,972	\$ 36.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	13,687	14,886	393,770	26.45	4
5	CNAs & Orderlies	27,293	29,537	439,369	14.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	183	245	3,365	13.73	9
10	Activity Assistants	4,558	5,045	75,582	14.98	10
11	Social Service Workers	10,240	11,401	221,820	19.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,993	19,555	298,877	15.28	15
16	Dishwashers	1,478	1,659	23,124	13.94	16
17	Maintenance Workers	4,499	5,088	80,026	15.73	17
18	Housekeepers	8,949	10,142	153,151	15.10	18
19	Laundry	1,960	2,004	30,765	15.35	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,541	3,893	63,716	16.37	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	2,261	2,436	43,326	17.79	31
32	Other Health Care(specify)					32
33	Other(specify)	14,175	15,398	226,739	14.73	33
34	TOTAL (lines 1 - 33)	113,140	123,773	\$ 2,143,602 *	\$ 17.32	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	14,350	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	7	354	11-03	44
45	Social Service Consultant			12-03	45
46	Other(specify)				46
47	Infectious Disease Consultant		1,300	10-03	47
48					48
49	TOTAL (lines 35 - 48)	7	\$ 17,204		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	8	360	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 360		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
			\$	Workers' Compensation Insurance		\$ 71,321	IDPH License Fee		\$
				Unemployment Compensation Insurance		18,112	Advertising: Employee Recruitment		
				FICA Taxes		158,706	Health Care Worker Background Check		557
				Employee Health Insurance		108,366	(Indicate # of checks performed 15)		
				Employee Meals		29,310	Patient Background Checks		1,268
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		
				PENSION			Licenses, Dues & Fees		22,505
				UNIFORMS					
				MISC		8,597			
				401K		566	MADO ALLOCATION		741
							Less: Public Relations Expense		()
							Non-allowable advertising		()
							Yellow page advertising		()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		\$ 394,978			\$ 25,071
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		Amount
MANAGEMENT FEES			\$ 636,000			\$	Out-of-State Travel		\$
ADMINISTRATOR - MADO			104,148						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
ADELFLIA, LLC	ACCOUNTING		\$ 7,400						
BKD, LLP	ACCOUNTING		12,285						
H2HHS, INC	MANAGEMENT CONS		44,120						
MAEMAR, PC	REV VENTILATION REQ		125						
PERSONNEL PLANNERS, INC	UNEMP CONSULTING		1,470						
TERRANCE SULLIVAN CONS	STRATEGIC PLANNING CON		1,467						
	PROF FEES - MISC		(600)						
FMS LAW GROUP	LEGAL		220						
BERGER, NEWMAND & FENCHEI	LEGAL		1,652				Seminar Expense		466
TED GIBBS ESQ.	LEGAL		263						
	DATA PROCESSING		48,138						
	LEGAL (NONALLOW)		13,822						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 466

*** 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:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 523 Line 10-02

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 0
This amount is to be recorded on line 42 of Schedule V.

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

YES

NO

YES

15 yrs

10-02

YES

NO

X

X

0

NO

- (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? N/A

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 29,310 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

NO

29,310

N/A

NO

N/A

NO

NO

N/A

NO

YES

YES