FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0054122

Facility Name: Mado Healthcare Buena Park

Address: 940 West Cullom Ave (Number) Chicago (City) 60613 (Zip Code)

County: Cook

Telephone Number: '(773) 525-9000 **Fax #** (773) 525-8016

HFS ID Number:

Date of Initial License for Current Owners: 8/7/1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rob Schlicht **Telephone Number:** (414) 431-9335
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 01/01/2025 to 12/31/2025 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) Peter J.O'Brien Sr
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Rob Schlicht, Director
(Firm Name & Address) Wipfli LLC, 10000 Innovation Drive, Suite 250, Milwaukee, WI 53226
(Telephone) (414) 431-9335 Fax # (414) 431-9335

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF	2,507	23,096	7,280		22		47	32,952	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,507	23,096	7,280		22		47	32,952	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 91.19%

D. How many bed reserve days during this year were paid by the Department?
648 (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 [x]

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

I. On what date did you start providing long term care at this location?
Date started 1969

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	324,580	22,943	18,330	365,853		365,853		365,853			1
2	Food Purchase		187,680		187,680		187,680		187,680			2
3	Housekeeping	175,412	67,126	7,167	249,705		249,705		249,705			3
4	Laundry		36,593		36,593		36,593		36,593			4
5	Heat and Other Utilities			108,075	108,075		108,075	650	108,725			5
6	Maintenance	383,906		164,552	548,458		548,458	23,116	571,574			6
7	Other (specify):*							4,576	4,576			7
8	**TOTAL General Services**	883,898	314,342	298,124	1,496,364		1,496,364	28,342	1,524,706			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	743,900	36,666	47,189	827,755		827,755	(726)	827,029			10
10a	Therapy											10a
11	Activities	205,467	53,535		259,002		259,002		259,002			11
12	Social Services	372,264	540	54,711	427,515		427,515		427,515			12
13	CNA Training											13
14	Program Transportation		198	9,758	9,956		9,956	24	9,980			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,321,631	90,939	125,658	1,538,228		1,538,228	(702)	1,537,526			16
	C. General Administration											
17	Administrative	95,330		390,000	485,330		485,330	(351,894)	133,436			17
18	Directors Fees											18
19	Professional Services			118,487	118,487		118,487	6,072	124,559			19
20	Dues, Fees, Subscriptions & Promotions			64,216	64,216		64,216	(52,663)	11,553			20
21	Clerical & General Office Expenses	70,482	12,208	124,525	207,215		207,215	244,355	451,570			21
22	Employee Benefits & Payroll Taxes			351,268	351,268		351,268		351,268			22
23	Inservice Training & Education											23
24	Travel and Seminar			443	443		443		443			24
25	Other Admin. Staff Transportation							8,960	8,960			25
26	Insurance-Prop.Liab.Malpractice			219,765	219,765		219,765		219,765			26
27	Other (specify):*							30,735	30,735			27
28	**TOTAL General Administration**	165,812	12,208	1,268,704	1,446,724		1,446,724	(114,435)	1,332,289			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,371,341	417,489	1,692,486	4,481,316		4,481,316	(86,795)	4,394,521			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.

Facility Name & ID Number Mado Healthcare Buena Park #0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,959	17,959		17,959	20,197	38,156			30
31	Amortization of Pre-Op. & Org.			283	283		283		283			31
32	Interest			23,675	23,675		23,675	88,624	112,299			32
33	Real Estate Taxes			184,720	184,720		184,720	(26,251)	158,469			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			5,513	5,513		5,513		5,513			35
36	Other (specify):*											36
37	**TOTAL Ownership**			592,150	592,150		592,150	(277,430)	314,720			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,625	1,625		1,625	(1,625)	0			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			10,656	10,656		10,656	(10,656)				43
44	**TOTAL Special Cost Centers**			12,281	12,281		12,281	(12,281)	0			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,371,341	417,489	2,296,917	5,085,747		5,085,747	(376,506)	4,709,241			45

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	(23,605)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(702)	30		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	(20)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,439)	21		19
20	Contributions	(38,000)	20		20
21	Owner or Key-Man Insurance	(6,342)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,241)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(658)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(68,493)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (161,500)		$	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)			34
35	Other- Attach Schedule	(170,305)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (170,305)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (331,805)		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

Mado Healthcare Buena Park

ID# 0054122

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Barber and Beauty Shops	(1,625)	40	3
4				4
5	Misc-Client's Clothing	(726)	10	5
6	Cigarette Purchases	(10,656)	43	6
7	Bank Charges	(1,009)	21	7
8	Annual Report Charges	(16,613)	20	8
9	Adjustments to Tax bill	(37,864)	33	9
10	Bldg Co Mgmt Fee	(35,897)	17	10
11	Bldg Co trust fees	(186)	21	11
12	Bldg Co liceenses	(25)	20	12
13	Bldg Co office supplies	(26)	21	13
14	Bldg Co legal	(992)	19	14
15	Bldg Co professional fees	(7,564)	21	15
16	Bldg Co bank charges	(11)	21	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**	(113,194)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	650	0	0	0	0	0	0	0	0	650	5
6	Maintenance	0	0	23,116	0	0	0	0	0	0	0	0	23,116	6
7	Other (specify):*	0	0	4,576	0	0	0	0	0	0	0	0	4,576	7
8	**TOTAL General Services**	0	0	28,342	0	0	0	0	0	0	0	0	28,342	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	(726)	0	0	0	0	0	0	0	0	0	0	(726)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	24	0	0	0	0	0	0	0	0	24	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(726)	0	24	0	0	0	0	0	0	0	0	(702)	16
	C. General Administration													
17	Administrative	(35,897)	35,897	(351,894)	0	0	0	0	0	0	0	0	(351,894)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(992)	992	6,072	0	0	0	0	0	0	0	0	6,072	19
20	Fees, Subscriptions & Promotions	(54,638)	25	1,950	0	0	0	0	0	0	0	0	(52,663)	20
21	Clerical & General Office Expenses	(63,101)	7,787	299,669	0	0	0	0	0	0	0	0	244,355	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	8,960	0	0	0	0	0	0	0	0	8,960	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	30,735	0	0	0	0	0	0	0	0	30,735	27
28	**TOTAL General Administration**	(154,628)	44,701	(4,508)	0	0	0	0	0	0	0	0	(114,435)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(155,354)	44,701	23,858	0	0	0	0	0	0	0	0	(86,795)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 **Report Period Beginning:** 01/01/2025 **Ending:** 12/31/2025

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(702)	10,765	10,134	0	0	0	0	0	0	0	0	20,197	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	85,528	3,096	0	0	0	0	0	0	0	0	88,624	32
33	Real Estate Taxes	(37,864)	1,206	10,407	0	0	0	0	0	0	0	0	(26,251)	33
34	Rent-Facility & Grounds	0	(360,000)	0	0	0	0	0	0	0	0	0	(360,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,566)	(262,501)	23,637	0	0	0	0	0	0	0	0	(277,430)	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	(1,625)	0	0	0	0	0	0	0	0	0	0	(1,625)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,656)	0	0	0	0	0	0	0	0	0	0	(10,656)	43
44	**TOTAL Special Cost Centers**	(12,281)	0	0	0	0	0	0	0	0	0	0	(12,281)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(206,201)	(217,800)	47,495	0	0	0	0	0	0	0	0	(376,506)	45

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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
See Ownership Listing-1		See Page 6-Supplemental		See Page 6-Supplemental		

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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 360,000	Long Term Care LP		$	$ (360,000)	1
2	V	32	Interest	23,675	Long Term Care LP		109,202	85,528	2
3	V	33	Real Estate Tax	184,720	Long Term Care LP		185,926	1,206	3
4	V	30	DEPRECIATIONS		Long Term Care LP		10,765	10,765	4
5	V	17	MANAGEMENT FEES		Long Term Care LP		35,897	35,897	5
6	V	21	TRUST FEES		Long Term Care LP		186	186	6
7	V	20	LICENSES & FEES		Long Term Care LP		25	25	7
8	V	21	OFFICE SUPPLIES		Long Term Care LP		26	26	8
9	V	19	LEGAL FEES		Long Term Care LP		992	992	9
10	V	21	PROFESSIONAL FEES		Long Term Care LP		7,564	7,564	10
11	V	21	BANK CHARGES		Long Term Care LP		11	11	11
12	V								12
13	V								13
14	Total			$ 568,394			$ 350,594	$ * (217,800)	14

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	MADO MGMT. LP		$ 650	$ 650	15
16	V	6	Maintenance		MADO MGMT. LP		23,116	23,116	16
17	V	7	Maintenance (other)		MADO MGMT. LP		4,576	4,576	17
18	V	14	Program Transportation		MADO MGMT. LP		24	24	18
19	V	17	Administrative		MADO MGMT. LP		1,197	1,197	19
20	V	19	Professional Services		MADO MGMT. LP		6,072	6,072	20
21	V	20	Dues, Fees, Subscriptions & Promotions		MADO MGMT. LP		1,950	1,950	21
22	V	21	Clerical & General Office Expenses		MADO MGMT. LP		299,669	299,669	22
23	V	25	Travel and Seminar		MADO MGMT. LP		8,960	8,960	23
24	V	27	Admin Others		MADO MGMT. LP		23,637	23,637	24
25	V	30	Depreciation		MADO MGMT. LP		10,134	10,134	25
26	V	32	Interest		MADO MGMT. LP		3,096	3,096	26
27	V	33	Real Estate Taxes		MADO MGMT. LP		10,407	10,407	27
28	V								28
29	V	17	Management Fees	390,000	MADO MGMT. LP			(390,000)	29
30	V								30
31	V	17	Salary - P. O'Brien		MADO MGMT. LP		36,909	36,909	31
32	V	27	Emp Ben - P. O'Brien		MADO MGMT. LP		7,098	7,098	32
33	V								33
34	V	17	Administrator Salary		MADO MGMT. LP				34
35	V	27	Gen Admin - Emp Ben		MADO MGMT. LP				35
36	V								36
37	V								37
38	V								38
39	Total			$ 390,000			$ 437,495	$ * 47,495	39

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing outside labor	$ 33,020	Mado, LLC		$ 33,020	$	15
16	V	12	Social Service Director	54,711	Mado, LLC		54,711		16
17	V	01	Dietician Outside Labor	18,330	Mado, LLC		18,330		17
18	V	06	Maintenance Outside Labor	85,013	Mado, LLC		85,013		18
19	V	21	Office Outside Labor	63,368	Mado, LLC		63,368		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			$ 254,442			$ 254,442	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Mado Healthcare Buena Park

ID# **0054122**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

Mado Management LP

Long Term Care LP

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	BRIDGET STUMPF GIFT DESCENDANTS TRUST								1
2	Beneficiary:								2
3	Bridget	A	Stumpf	Chicago	IL	15.36828	15.36828	15.36828	3
4									4
5	BRIDGET STUMPF CHICAGO DESCENDANTS TRUST								5
6	Beneficiary:								6
7	Bridget	A	Stumpf	Chicago	IL	3.93125	3.93125	3.93125	7
8									8
9	CAITLIN O'BRIEN GIFT DESCENDANTS TRUST								9
10	Beneficiary:								10
11	Catlin	M	O'Brien	Chicago	IL	5.60570	5.60570	5.60570	11
12									12
13	CAITLIN O'BRIEN GIFT DESCENDANTS TRUST								13
14	Beneficiary:								14
15	Catlin	M	O'Brien	Chicago	IL	1.86845	1.86845	1.86845	15
16									16
17	CHARLES STUMPF JR. GIFT DESCENDANTS TRUST								17
18	Beneficiary:								18
19	Charles	F	Stumpf Jr.	Berwyn	IL	15.36828	15.36828	15.36828	19
20									20
21	CHARLES STUMPF CHICAGO DESCENDANTS TRUST								21
22	Beneficiary:								22
23	Charles	F	Stumpf Jr.	Berwyn	IL	3.93125	3.93125	3.93125	23
24									24
25	REENIE O'BRIEN GIFT DESCENDANTS TRUST								25
26	Beneficiary:								26
27	Maureen	V	King	Chicago	IL	5.60570	5.60570	5.60570	27
28									28
29	REENIE O'BRIEN DESCENDANTS TRUST								29
30	Beneficiary:								30
31	Maureen	V	King	Chicago	IL	1.86845	1.86845	1.86845	31
32									32
33	MEGHAN O'BRIEN GIFT DESCENDANTS TRUST								33
34	Beneficiary:								34
35	Meghan	E	Williams	Skokie	IL	5.60570	5.60570	5.60570	35
36									36
37	MEGHAN O'BRIEN DESCENDANT TRUST								37
38	Beneficiary:								38
39	Meghan	E	Williams	Skokie	IL	1.86845	1.86845	1.86845	39
40									40
41	PETER J. O'BRIEN, SR. GIFT DESCENDANTS TRUST								41
42	Beneficiary:								42
43	Peter	J	O'Brien Sr.	Chicago	IL	31.50512	31.50512	31.50512	43
44									44
45	PETER J. O'BRIEN, SR. CHICAGO DESCENDANTS TRUST								45
46	Beneficiary:								46
47	Peter	J	O'Brien Sr.	Chicago	IL	6.37451	6.37451	6.37451	47
48									48
49	Peter	J	O'Brien Sr.	Chicago	IL	1.09889	1.09889	1.09889	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									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Mado Healthcare Buena Park

ID# **0054122**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
96									96
97									97
98									98
99									99
100									100
101									101
102									102
103									103
104									104
105									105
106									106
107									107
108									108
109									109
110									110
111									111
112									112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125									125
126									126
127									127
128									128
129									129
130									130
131									131
132									132
133									133
134									134
135									135
136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Mado Healthcare - Old Town	Chicago			Long Term Care LP	Chicago	Building Co.	1
2	Mado Healthcare - Uptown	Chicago			Mado Management	Chicago	Bookkeeping	2
3	Mado Healthcare - Douglas Park	Chicago			Mado LLC	Chicago		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 Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Peter O'Brien	Shareholder	Administrtive	0.01	See Attahced	9.11	0.20	Alloc Salary	$ 39,609	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	$ 39,609		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 Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 [x] 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	5	Heat and Other Utilities	PATIENT DAYS	168,929	4	$ 3,259	$	32,952	$ 636	1
2	6	Maintenance	PATIENT DAYS	168,929	4	115,914		32,952	22,611	2
3	7	Maintenance (other)	PATIENT DAYS	168,929	4	22,944		32,952	4,476	3
4	14	Program Transportation	PATIENT DAYS	168,929	4	121		32,952	24	4
5	17	Administrative	PATIENT DAYS	168,929	4	6,001		32,952	1,171	5
6	19	Professional Services	PATIENT DAYS	168,929	4	30,446		32,952	5,939	6
7	20	Dues, Fees, Subscriptions & Prom	PATIENT DAYS	168,929	4	9,779		32,952	1,908	7
8	21	Clerical & General Office Expens	PATIENT DAYS	168,929	4	1,502,638		32,952	293,111	8
9	24	Travel and Seminar	PATIENT DAYS	168,929	4	44,926		32,952	8,763	9
10	27	Admin Others	PATIENT DAYS	168,929	4	118,520		32,952	23,119	10
11	30	Depreciation	PATIENT DAYS	168,929	4	50,814		32,952	9,912	11
12	32	Interest	PATIENT DAYS	168,929	4	15,524		32,952	3,028	12
13	33	Real Estate Taxes	PATIENT DAYS	168,929	4	52,184		32,952	10,179	13
14										14
15	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	4	200,000	200,000	9	39,609	15
16	17	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	4	35,840		9	7,098	16
17										17
18	17	Administrator Salary	Direct Allocation	4	3	0		0	0	18
19										19
20	27	Gen Admin - Emp Ben	Direct Allocation	4	3	67,714		0	0	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,276,624	$ 200,000		$ 431,584	25

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 [x] NO [ ]

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

Name of Related Organization: MADO LLC
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	10	NURSING OUTSIDE LABOR	Direct			$	$		$ 33,020	1
2	12	SOCIAL SERVICE DIRECTOR	Direct						54,711	2
3	01	DIETITIAN OUTSIDE LABOR	Direct						18,329	3
4	06	MAINTENANCE O/S LABOR	Direct						85,013	4
5	21	OFFICE OUTSIDE LABOR	Direct						63,368	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					$	$		$ 254,441	25

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Signature Bank		X	Mortgage			$	$ 1,401,784			$ 109,202	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PARKWAY BANK		X	Line of Credit							9,405	6
7	SIGNATURE BANK		X	Line of Credit							14,269	7
8												8
9	TOTAL Facility Related						$	$ 1,401,784			$ 132,877	9
	B. Non-Facility Related*											
10	Interest Incom - Bldg Co.		X								(23,675)	10
11	Allocated from Mado Mgmt	X									3,096	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20,579)	14
15	TOTALS (line 9+line14)						$	$ 1,401,784			$ 112,298	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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.)

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	216,741	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.)	$	193,327	2
3. Under or (over) accrual (line 2 minus line 1).	$	(23,414)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$	181,853	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.	$	158,439	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020	133,946	9
	2021	162,776	10
	2022	164,973	11
	2023	183,751	12
	2024	173,222	13

2024 Accrual = 173222*1.05 = 181883

Allocated from Mado Mgmt LP = $10,407

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mado Healthcare Buena Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054122

CONTACT PERSON REGARDING THIS REPORT Steven N. Lavenda

TELEPHONE 847 282-6300 FAX #: 847 282-6301

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-406-005-0000		$ 184,719.59	$ 184,719.59
2.	17-10-132-041-0000	Home Office (see attachment)	$ 8,607.36	$ 8,607.36
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 193,326.95	$ 193,326.95

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

Facility Name & ID Numb Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,000 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease. N/A

I. Are you presently operating under a sublease agreement? No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES NO X If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over.

N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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			1969	23,125		20			23,125	9
10	Various			1970	19,000		20			19,000	10
11	Various			1972	20,000		20			20,000	11
12	Various			1973	16,751		20			16,751	12
13	Various			1974	5,550		20			5,550	13
14	Various			1975	118,165		20			118,165	14
15	Various			1978	20,810		20			20,810	15
16	Various			1979	15,068		20			15,068	16
17	Various			1980	25,336		20			25,336	17
18	Various			1981	2,395		20			2,395	18
19	Various			1984	1,478		20			1,478	19
20	Various			1985	4,127		20			4,127	20
21	Various			1986	3,495		20			3,495	21
22	Various			1988	20,920		20			20,920	22
23	Various			1990	62,014		20			62,014	23
24	Various			1991	28,600		20			28,600	24
25	Various			1992	15,024		20			15,024	25
26	Various			1993	3,690		20			3,690	26
27	Various			1994	14,277		20			14,277	27
28	Various			1995	7,210		20			7,210	28
29	Various			1996	27,290		20			27,290	29
30	Various			1997	11,518		20			11,518	30
31	Various			1998	4,510		20			4,510	31
32	Various			1999	18,958		20			18,958	32
33	Various			2000	92,517		20			92,517	33
34	Various			2001	22,366		20			22,366	34
35	Various			2002	56,931		20			56,931	35
36	Various			2003	99,578		20			99,578	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 Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	2004	$ 112,088	$	20	$	$	$ 112,088	37
38	Various	2006	33,745		20	1,687	1,687	32,058	38
39	Various	2007	21,711		20	1,086	1,086	19,540	39
40	Various	2008	83,890		20	4,195	4,195	71,307	40
41	Various	2010	42,602		20	2,130	2,130	31,952	41
42	Various	2012	14,950		20	748	748	9,718	42
43	Various	2013	3,150		20	158	158	1,890	43
44	Various	2014	11,345		20	567	567	6,240	44
45	Various	2015	2,580		20	129	129	1,290	45
46	Various	2017	76,719		20	3,836	3,836	30,688	46
47	Various	2018	7,650		20	383	383	2,678	47
48	Various	2019	301,701		20	15,085	15,085	90,510	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12C)		279,421	20,899		11,427	(9,472)	73,306	68
69	Financial Statement Depreciation			17,959			(17,959)		69
70	TOTAL (lines 4 thru 69)		$ 1,752,255	$ 38,858		$ 41,429	$ 2,571	$ 1,243,965	70

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 12A, Carried Forward		$ 1,752,255	$ 38,858		$ 41,429	$ 2,571	$ 1,243,965	1
2	Replace 6 burners, switching relay for boiler	2022	3,640		20	182	182	546	2
3	Replacement of steam boiler	2023	47,000		20	2,350	2,350	4,700	3
4	Install new hydraulic elevator motor	2023	6,654		20	333	333	665	4
5	Repair leaking hydraulic fittings on elevator	2023	2,673		20	134	134	267	5
6	Rebuilt 3 backflow devices in boiler rooms & laundry rm	2023	2,690		20	135	135	269	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,814,912	$ 38,858		$ 44,562	$ 5,704	$ 1,250,413	34

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 12B, Carried Forward		$ 1,814,912	$ 38,858		$ 44,562	$ 5,704	$ 1,250,413	1
2									2
3	Buildings								3
4	Allocated from Mado Management LP	2018	118,287		39	3,033	3,033	21,231	4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management LP	2018	6,737		10	674	674	4,716	9
10	Allocated from Mado Management LP	2018	2,672		20	134	134	935	10
11	Allocated from Mado Management LP	2018	18,456		20	923	923	6,460	11
12	Allocated from Mado Management LP	2018	86,885	20,899	20	4,344	(16,555)	30,410	12
13	Allocated from Mado Management LP	2020	25,965		20	1,298	1,298	6,491	13
14	Allocated from Mado Management LP	2022	20,419		20	1,021	1,021	3,063	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,094,333	$ 59,757		$ 55,988	$ (3,769)	$ 1,323,718	34

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 4,271	$	$ 1,651	$ 1,651	10	$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	376,878						73
74								74
75	TOTALS	$ 381,149	$	$ 1,651	$ 1,651		$	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		2011 Toyota Sienna Van	2019	$ 7,056	$	$ 1,416	$ 1,416		$ 5,640	76
77		Alloc from Mado Mgmt LP								77
78										78
79										79
80	TOTALS			$ 7,056	$	$ 1,416	$ 1,416		$ 5,640	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)	$ 2,502,538	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 59,757	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,055	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (702)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,329,358	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.

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,513 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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)	$			

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	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (last day of reporting year)

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	$ 1,541,840	$ 1,565,421	1
2	Cash-Patient Deposits	36,895	36,895	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	631,191	631,191	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,091	19,091	6
7	Other Prepaid Expenses	8,325	8,325	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	45,240	45,240	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,282,582	$ 2,306,163	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		166,232	13
14	Buildings, at Historical Cost		389,474	14
15	Leasehold Improvements, at Historical Cost	1,332,323	1,332,323	15
16	Equipment, at Historical Cost	388,202	388,202	16
17	Accumulated Depreciation (book methods)	(1,291,996)	(1,291,996)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	356,829	547,786	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 785,358	$ 1,532,021	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,067,940	$ 3,838,184	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,375,544	$ 1,392,908	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,527	9,527	28
29	Short-Term Notes Payable	100,045	100,045	29
30	Accrued Salaries Payable	117,584	117,584	30
31	Accrued Taxes Payable (excluding real estate taxes)	(4,794)	(4,794)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		196,287	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	22,798	22,799	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,620,704	$ 1,834,356	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,293,130	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,293,130	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,620,704	$ 3,127,486	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,447,236	$ 710,698	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,067,940	$ 3,838,184	48

***(See instructions.)**

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (223,950)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (223,950)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,518,920	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	152,266	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,671,186	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)**	$ 1,447,236	24 *

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

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,827,020	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,827,020	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			28
28a	OTHER INCOME	777,647	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 777,647	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,604,667	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,496,364	31
32	Health Care	1,538,228	32
33	General Administration	1,446,724	33
	B. Capital Expense		
34	Ownership	592,150	34
	C. Ancillary Expense		
35	Special Cost Centers	12,281	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)***	$ 5,085,747	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,518,920	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,518,920	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 450,799.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	4,244,801.00	45
46	MMAI-Medicaid is the Primary Payer	1,125,339.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	6,080.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,827,019	56

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,510	1,527	61,192	40.07	3
4	Licensed Practical Nurses	8,963	9,041	363,332	40.19	4
5	CNAs & Orderlies	12,370	12,472	259,373	20.80	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	10,641	10,718	205,467	19.17	10
11	Social Service Workers	16,797	16,957	372,264	21.95	11
12	Dietician			0		12
13	Food Service Supervisor	4,085	4,119	89,764	21.79	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	12,529	12,646	234,816	18.57	15
16	Dishwashers			0		16
17	Maintenance Workers	22,417	22,623	383,906	16.97	17
18	Housekeepers	8,188	8,264	175,412	21.23	18
19	Laundry			0		19
20	Administrator			0		20
21	Assistant Administrator			0		21
22	Other Administrative	2,070	2,087	95,330	45.67	22
23	Office Manager			0		23
24	Clerical	2,756	2,777	70,482	25.38	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified ID Prof (QIDP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records	2,487	2,506	60,003	23.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,812	105,738	$ 2,371,341 *	$ 22.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	$1166.66/MONT	14,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	$100/MONTH	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,200		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	410	$ 33,669	10-03	50
51	Licensed Practical Nurses	315	12,321	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	725	$ 45,989		53

Facility Name & ID Number Mado Healthcare Buena Park # 0054122 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Jones, Althea S	Administrator		95,330
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,330

B. Administrative - Other

Description	Amount
Management Fees	$ 390,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 390,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PORCARO STOLAREK METE	DATA PROCESSING - MAI	$ 11,206
NINJA ONE	DATA PROCESSING - MAINT	1,111
INOVALON PROVIDER, INC.	DATA PROCESSING - MANAC	4,352
POINTCLICKCARE TECHNOLOG	DATA PROCESSING - MANAC	18,414
BLUE HOST/ZOOM	DATA PROCESSING - MANAC	526
ADP	DATA PROCESSING - MANAC	16,204
WIPFLI & DHJJ	CERTIFIED PUBLIC ACCOUN	7,292
MULTILIGUAL CONNECTIONS	TRANSLATION SERVICES	381
H2HHS, INC.	MANAGEMENT CONSULTAN	48,400
RJK CREATIVES	GRAPHIC DESIGNE -ONBOAI	439
PERSONNEL PLANNERS, INC.	UNEMPLOYMENT CONSULT	870
LANER MUCHIN, LTD. & LANER	LEGAL FEES	9,292
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 118,487

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,284
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	14,975
Illinois Municipal Retirement Fund (IMRF)*	
Payroll taxes	178,723
Group Insurance	124,988
401K-Employers Share	3,671
Employee Welfare	5,626
TOTAL (agree to Schedule V, line 22, col.8)	$ 351,268

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,445
Association Dues (total from pg 22, #4)	
Donations	
Licenses, Dues & fees	
Allocated from Mado Mgmt. Lp	1,975
ADVERTISING & RECRUITMENT	8,158
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,578

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SAFE DINING ASSOCIATION	443
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 443

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mado Healthcare Buena Park **#** 0054122 **Report Period Beginning:** 01/01/2025 **Ending:** 12/31/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
Total	

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Total	

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ **0** Line

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

(7) 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.

(8) 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.

(9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,975** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**

d. Have vehicle usage logs been maintained? **N/A**

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**

(13) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(15) 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.