

		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: <u>0054106</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Mado Healthcare Douglas Park</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1550 S Albany Avenue</u> <u>Chicago</u> <u>60623</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(773) 277-6868</u> Fax # <u>(773) 277-6868</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Patrick Carroll</u> <u>Senior Manager</u></td></tr><tr><td>(Firm Name & Address) <u>Wipfli Advisory LLC</u> <u>4890 Owen Ayres Court, Eau Claire WI 54701</u></td></tr><tr><td>(Telephone) <u>(414) 259-6792</u> Fax # <u>(414) 259-6792</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Patrick Carroll</u> <u>Senior Manager</u>	(Firm Name & Address) <u>Wipfli Advisory LLC</u> <u>4890 Owen Ayres Court, Eau Claire WI 54701</u>	(Telephone) <u>(414) 259-6792</u> Fax # <u>(414) 259-6792</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																																				
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Date of Initial License for Current Owners: <u>2/1/1971</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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In the event there are further questions about this report, please contact:																																																	
Name: <u>Patrick Carroll</u> Telephone Number: <u>(414) 259-6792</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	172	Intermediate (ICF)	172	62,780	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF	2,432	39,057	4,771		71		3	46,334	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,432	39,057	4,771		71		3	46,334	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 73.80%

D. How many bed reserve days during this year were paid by the Department? 1,663 (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 07/01/1971

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number **Mado Healthcare Douglas Park** # **0054106** 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 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	400,191	56,206	18,998	475,395		475,395		475,395			1
2	Food Purchase		324,410		324,410		324,410	(289)	324,121			2
3	Housekeeping	274,317	81,094		355,411		355,411		355,411			3
4	Laundry	40,104	51,185		91,289		91,289		91,289			4
5	Heat and Other Utilities			160,778	160,778		160,778	914	161,692			5
6	Maintenance	825,221		225,701	1,050,922		1,050,922	32,505	1,083,427			6
7	Other (specify):*							6,434	6,434			7
8	TOTAL General Services	1,539,833	512,895	405,477	2,458,205		2,458,205	39,564	2,497,769			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	1,055,785	54,373	221,130	1,331,288		1,331,288		1,331,288			10
10a	Therapy											10a
11	Activities	150,432	73,663		224,095		224,095		224,095			11
12	Social Services	539,169	1,064	46,820	587,053		587,053		587,053			12
13	CNA Training											13
14	Program Transportation			4,515	4,515		4,515	34	4,549			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,745,386	129,100	286,465	2,160,951		2,160,951	34	2,160,985			16
	C. General Administration											
17	Administrative	145,399		763,500	908,899		908,899	(658,839)	250,060			17
18	Directors Fees											18
19	Professional Services			196,120	196,120		196,120	(26,326)	169,794			19
20	Dues, Fees, Subscriptions & Promotions			99,865	99,865		99,865	(47,343)	52,522			20
21	Clerical & General Office Expenses	145,531	18,591	118,130	282,252		282,252	398,236	680,488			21
22	Employee Benefits & Payroll Taxes			505,093	505,093		505,093		505,093			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			64	64		64	12,598	12,662			25
26	Insurance-Prop.Liab.Malpractice			377,982	377,982		377,982		377,982			26
27	Other (specify):*							64,582	64,582			27
28	TOTAL General Administration	290,930	18,591	2,060,754	2,370,275		2,370,275	(257,092)	2,113,183			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,576,149	660,586	2,752,696	6,989,431		6,989,431	(217,494)	6,771,937			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			74,179	74,179		74,179	61,744	135,923			30
31	Amortization of Pre-Op. & Org.			1,982	1,982		1,982		1,982			31
32	Interest			40,136	40,136		40,136	21,093	61,229			32
33	Real Estate Taxes			270,188	270,188		270,188	37,286	307,474			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(498,000)				34
35	Rent-Equipment & Vehicles			5,230	5,230		5,230		5,230			35
36	Other (specify):*											36
37	TOTAL Ownership			889,715	889,715		889,715	(377,877)	511,838			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			8,354	8,354		8,354	(8,354)				43
44	TOTAL Special Cost Centers			8,354	8,354		8,354	(8,354)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,576,149	660,586	3,650,765	7,887,500		7,887,500	(603,725)	7,283,775			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	32,359	30		9
10	Interest and Other Investment Income	(20,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(289)	2		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	(10,633)	21		19
20	Contributions	(50,010)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,270)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,057)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	25,865			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,035)		\$	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)	(517,881)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (517,881)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (552,916)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	0	0	2
3		0	0	3
4	TRAFFIC VIOLATIONS	(185)	21	4
5	LICENSES, DUES & FEES	(75)	20	5
6	ACTIVITY - CIGARETTES	(8,354)	43	6
7	BANK CHARGES	0	0	7
8	Management Fees	(50,475)	17	8
9	Trust Fees	(262)	21	9
10	Licenses & Fees	(35)	20	10
11	Legal Fees	(37)	19	11
12	PROFESSIONAL FEES	0	19	12
13	BANK CHARGES	0	21	13
14	Adjustments to tax bill	34,480	33	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	(24,944)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 498,000	Long Term Care LP		\$	(498,000)	1
2	V	32	Interest	40,136	Long Term Care LP		76,876	36,740	2
3	V	33	Real Estate Tax	270,188	Long Term Care LP		258,362	(11,826)	3
4	V	30	Depreciation		Long Term Care LP		15,136	15,136	4
5	V	17	Management Fees		Long Term Care LP		50,475	50,475	5
6	V	21	Trust Fees		Long Term Care LP		262	262	6
7	V	20	Licenses & Fees		Long Term Care LP		35	35	7
8	V	19	Legal Fees		Long Term Care LP		37	37	8
9	V	19	PROFESSIONAL FEES		Long Term Care LP		10,636	10,636	9
10	V	21	BANK CHARGES		Long Term Care LP		15	15	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 808,325			\$ 411,834	\$ * (396,491)	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	Heat and Other Utilities	\$	MADO MGMT. LP		\$ 914	\$ 914	15
16	V	6	Maintenance		MADO MGMT. LP		32,505	32,505	16
17	V	7	Maintenance (other)		MADO MGMT. LP		6,434	6,434	17
18	V	14	Program Transportation		MADO MGMT. LP		34	34	18
19	V	17	Administrative		MADO MGMT. LP		1,683	1,683	19
20	V	19	Professional Services	45,500	MADO MGMT. LP		8,538	(36,962)	20
21	V	20	Dues, Fees, Subscriptions & Promotions		MADO MGMT. LP		2,742	2,742	21
22	V	21	Clerical & General Office Expenses		MADO MGMT. LP		421,366	421,366	22
23	V	25	Travel and Seminar		MADO MGMT. LP		12,598	12,598	23
24	V	27	Admin Others		MADO MGMT. LP		33,235	33,235	24
25	V	30	Depreciation		MADO MGMT. LP		14,249	14,249	25
26	V	32	Interest		MADO MGMT. LP		4,353	4,353	26
27	V	33	Real Estate Taxes		MADO MGMT. LP		14,633	14,633	27
28	V								28
29	V	17	Management Fees	718,000	MADO MGMT. LP			(718,000)	29
30	V								30
31	V	17	Salary - P. O'Brien		MADO MGMT. LP		57,478	57,478	31
32	V	27	Emp Ben - P. O'Brien		MADO MGMT. LP		10,300	10,300	32
33	V								33
34	V	17	Administrator Salary	145,399	MADO MGMT. LP		145,399		34
35	V	27	Gen Admin - Emp Ben		MADO MGMT. LP		21,047	21,047	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 908,899			\$ 787,508	\$ * (121,391)	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	10	NURSING-O/L MADO	\$ 17,150	MADO LLC		\$ 17,150	\$	15
16	V	12	SOCIAL SRVC- O/L MADO	46,820	MADO LLC		46,820		16
17	V	01	DIETARY SALARIES-O/L MADO	16,068	MADO LLC		16,068		17
18	V	06	MAINTENANCE O/L MADO	84,468	MADO LLC		84,468		18
19	V	21	OFFICE SAL. O/L MADO	53,856	MADO LLC		53,856		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			\$ 218,362			\$ 218,362	\$ *	39

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

STATE OF ILLINOIS				Ownership Listing-1				
Mado Healthcare Douglas Park								
ID#		0054106						
Report Period Beginning:		01/01/2025		Mado Management				
Ending:		12/31/2025		Long Term Care LP				
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management				
-Owners of companies must be listed instead of company names.				Operator/Licensee		Building Co.	Co./Home Office	
-Names of trust beneficiaries must be listed.				Ownership Percentage		Ownership Percentage	Ownership Percentage	
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	BRIDGET STUMPF GIFT DESCENDANTS TRUST							1
2	Beneficiary:							2
3	Bridget	A	Stumpf	Chicago	IL	15.36828	15.36828	15.36828
4								4
5	BRIDGET STUMPF CHICAGO DESCENDANTS TRUST							5
6	Beneficiary:							6
7	Bridget	A	Stumpf	Chicago	IL	3.93125	3.93125	3.93125
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
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
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
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
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
28								28
29	REENIE O'BRIEN DESCENDANTS TRUST							29
30	Beneficiary:							30
31	Maureen	V	King	Chicago	IL	1.86845	1.86845	1.86845
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
36								36
37	MEGHAN O'BRIEN DESCENDANT TRUST							37
38	Beneficiary:							38
39	Meghan	E	Williams	Skokie	IL	1.86845	1.86845	1.86845
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
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
48								48
49	Peter	J	O'Brien Sr.	Chicago	IL	1.09889	1.09889	1.09889
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

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 - Buena Park	Chicago			Mado Management	Chicago	Bookkeeping	2
3	Mado Healthcare - Uptown	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

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	Shareholder	Administrtive	0.01	See Attahced	13.22	0.29	Alloc Salary	\$ 57,478	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	\$ 57,478		13

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

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

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 Report Period Beginning: 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 ☒ NO ☐

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

Name of Related Organization MADO MGMT LP
Street Address 405 N. WABASH UNIT P2W
City / State / Zip Code CHICAGO, IL. 60611
Phone Number (312) 787-9400
Fax Number (312) 787-9434

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	PATIENT DAYS	165,232	4	\$ 3,259	\$	46,334	\$ 914	1
2	6	Maintenance	PATIENT DAYS	165,232	4	115,914		46,334	32,504	2
3	7	Maintenance (other)	PATIENT DAYS	165,232	4	22,944		46,334	6,434	3
4	14	Program Transportation	PATIENT DAYS	165,232	4	121		46,334	34	4
5	17	Administrative	PATIENT DAYS	165,232	4	6,001		46,334	1,683	5
6	19	Professional Services	PATIENT DAYS	165,232	4	30,446		46,334	8,538	6
7	20	Dues, Fees, Subscriptions & Prom	PATIENT DAYS	165,232	4	9,779		46,334	2,742	7
8	21	Clerical & General Office Expens	PATIENT DAYS	165,232	4	1,502,638		46,334	421,366	8
9	24	Travel and Seminar	PATIENT DAYS	165,232	4	44,926		46,334	12,598	9
10	27	Admin Others	PATIENT DAYS	165,232	4	118,520		46,334	33,235	10
11	30	Depreciation	PATIENT DAYS	165,232	4	50,814		46,334	14,249	11
12	32	Interest	PATIENT DAYS	165,232	4	15,524		46,334	4,353	12
13	33	Real Estate Taxes	PATIENT DAYS	165,232	4	52,184		46,334	14,633	13
14										14
15										15
16										16
17	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	4	200,000	200,000	13	57,478	17
18	17	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	4	35,840		13	10,300	18
19										19
20	17	Administrator Salary	Direct Allocation						145,400	20
21										21
22	27	Gen Admin - Emp Ben	Direct Allocation		3	59,759			21,046	22
23										23
24										24
25	TOTALS					\$ 2,268,669	\$ 200,000		\$ 787,507	25

Facility Name & ID Number Mado Healthcare Douglas Park # 0054106 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 ☒ 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	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	10	Nursing Outside labor(O/L)	Direct	1		\$	\$		\$ 17,150	1
2	12	Social Services Outside labor(O/L)	Direct	1					46,820	2
3	01	Dietary Outside labor(O/L)	Direct	1					16,068	3
4	06	Maintenance Outside labor(O/L)	Direct	1					84,468	4
5	21	Office Outside labor(O/L)	Direct	1					53,856	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					\$	\$		\$ 218,362	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	SIGNATURE BANK		X	Mortgage			\$	1,539,246			\$ 76,876	1
2												2
3												3
4												4
5												5
	Working Capital											
6	PARKWAY BANK		X	Line of Credit							19,331	6
7	SIGNATURE BANK		X	Line of Credit							20,806	7
8												8
9	TOTAL Facility Related						\$	1,539,246			\$ 117,012	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,000)	10
11	Interest Income - Bldg Co.		X								(40,136)	11
12	Allocated from Mado Mgmt	X									4,353	12
13												13
14	TOTAL Non-Facility Related						\$				\$ (55,783)	14
15	TOTALS (line 9+line14)						\$	1,539,246			\$ 61,229	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.)

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

B. Real Estate Taxes

[illegible]

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 Douglas Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054106

CONTACT PERSON REGARDING THIS REPORT PETER J. O'BRIEN, SR.

TELEPHONE (312)-787-9400 FAX #: (312)-787-9590

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)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-24-106-035	Long Term Care Property	\$ 1,082.06	\$ 1,082.06
2. 16-24-106-036	Long Term Care Property	\$ 2,104.87	\$ 2,104.87
3. 16-24-106-037	Long Term Care Property	\$ 12,565.81	\$ 12,565.81
4. 16-24-106-032	Long Term Care Property	\$ 68,084.04	\$ 68,084.04
5. 16-24-106-033	Long Term Care Property	\$ 182,851.79	\$ 182,851.79
6. 16-24-106-034	Long Term Care Property	\$ 1,091.12	\$ 1,091.12
7. 16-24-106-016	Long Term Care Property	\$ 1,204.06	\$ 1,204.06
8. 16-24-106-017	Long Term Care Property	\$ 1,204.46	\$ 1,204.46
9.		\$	\$
10. 17-10-132-041-0000	Home Office (see attachment)	\$ 12,295.72	\$ 12,295.72
TOTALS		\$ 282,483.93	\$ 282,483.93

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 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 providecopies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940 B. General Construction Type: Exterior Frame 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?
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:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1	Facility				\$ 22,077	1	
2						2	
3	TOTALS				\$ 22,077	3	

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	172			1971	\$ 140,000	\$		\$		\$ 140,000	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1973	9,000		20			9,000	9	
10	Various			1975	16,880		20			16,880	10	
11	Various			1976	4,234		20			4,234	11	
12	Various			1977	43,234		20			43,234	12	
13	Various			1978	50,867		20			50,867	13	
14	Various			1979	40,393		20			40,393	14	
15	Various			1980	4,392		20			4,392	15	
16	Various			1981	15,817		20			15,817	16	
17	Various			1982	15,180		20			15,180	17	
18	Various			1984	7,505		20			7,505	18	
19	Various			1985	60,377		20			60,377	19	
20	Various			1986	41,792		20			41,792	20	
21	Various			1987	17,344		20			17,344	21	
22	Various			1988	13,840		20			13,840	22	
23	Various			1989	10,568		20			10,568	23	
24	Various			1990	48,324		20			48,324	24	
25	Various			1991	26,113		20			26,113	25	
26	Various			1992	105,671		20			105,671	26	
27	Various			1993	14,487		20			14,487	27	
28	Various			1994	37,950		20			37,950	28	
29	Various			1995	38,705		20			38,705	29	
30	Various			1996	34,431		20			34,431	30	
31	Various			1997	62,792		20			62,792	31	
32	Various			1998	73,236		20			73,236	32	
33	Various			1999	51,272		20			51,272	33	
34	Various			2000	120,486		20			120,486	34	
35	Various			2001	159,720		20			159,720	35	
36				2002	148,315		20			148,315	36	

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2003	\$ 140,910	\$	20	\$	\$	\$ 140,910	37
38	Various	2004	159,051		20			159,051	38
39	Various	2005	156,034		20			156,034	39
40	Various	2006	173,699		20	8,685	8,685	165,014	40
41	Various	2007	134,431		20	6,722	6,722	120,988	41
42	Various	2008	72,586		20	3,629	3,629	61,698	42
43	Various	2009	180,636		20	9,032	9,032	144,509	43
44	Various	2010	243,096		20	12,155	12,155	182,322	44
45	Various	2011	322,393		20	16,120	16,120	225,675	45
46	Various	2012	266,332		20	13,317	13,317	173,116	46
47	Various	2013	39,707		20	1,985	1,985	23,824	47
48	Various	2014	19,405		20	970	970	10,673	48
49	Various	2015	60,554		20	3,028	3,028	30,277	49
50	Various	2016	31,849		20	1,592	1,592	14,332	50
51	Various	2017	52,094		20	2,605	2,605	20,838	51
52	Various	2018	381,512		20	19,076	19,076	133,529	52
53	Various	2019	16,535		20	827	827	4,961	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								67
68	Related Party Allocations (Pages 12C)		405,333	29,385		16,576	(12,809)	106,338	68
69	Financial Statement Depreciation			65,210			(65,210)		69
70	TOTAL (lines 4 thru 69)		\$ 4,269,082	\$ 94,595		\$ 116,317	\$ 21,722	\$ 3,287,013	70

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

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

Report Period Beginning:

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	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		\$ 4,269,082	\$ 94,595		\$ 116,317	\$ 21,722	\$ 3,287,013	1
2	NEW CONDENSING UNIT-WALK IN FREEZER	2020	3,400		20	170	170	850	2
3	TUCKPOINT LIMESTONE PARAPET WALL - NORTH & EA	2020	5,700		20	285	285	1,425	3
4	WATER HEATER	2020	3,750		20	188	188	938	4
5	LAUNDRY ROOM RENOVATION-FLOORING/WALLS REPL	2020	77,455		20	3,873	3,873	19,364	5
6	ELEVATOR	2020	184,290		20	9,215	9,215	46,073	6
7	LAUNDRY ROOM WINDOWS	2020	3,750		20	188	188	938	7
8	Elevator-beam, relay box, min split, hydroulic valve, line replacme	2020	32,348		20	1,617	1,617	8,087	8
9	Replace smoke & heat detector in elevator machine room	2022	4,995		20	250	250	749	9
10	Elevator - replace hydraulic packings	2022	3,149		20	157	157	472	10
11	Replace pump motor on elevator	2022	3,132		20	157	157	470	11
12	Install 1/4" clear tempered plate glass for existing openings	2022	3,550		20	178	178	533	12
13	Replace shaft coupling on fire pump	2022	2,978		20	149	149	447	13
14	Fire pump repairs - install helia coil	2022	3,075		20	154	154	461	14
15	Install Window AC BTU	2023	2,509		20	125	125	251	15
16	Elevator seal and hydraulic repair	2023	4,360		20	218	218	436	16
17	Paint south section of facility	2023	5,480		20	274	274	548	17
18	Paint east section of facility	2023	5,480		20	274	274	548	18
19	Paint north section of facility	2023	5,480		20	274	274	548	19
20	Replace gauges on fire sprinkler system	2023	4,762		20	238	238	476	20
21	INSTALLED 2 NEW INJECTOR PUMPS 2 CHCK & 2 SHUT O	2024	13,500		20	675	675	675	21
22	INSTALLED ABOUT 50FT CHAIN AND 8 FT HEIGHT BARB V	2024	3,500		20	175	175	175	22
23	GRILL AND PATIO INSTALLATION	2025	18,982		20	949	949		23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Related Building Company								31
32	Related Party Allocations (Pages 12C)								32
33	Financial Statement Depreciation								33
34	TOTAL (lines 1 thru 33)		\$ 4,664,707	\$ 94,595		\$ 136,098	\$ 41,503	\$ 3,371,475	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$4,664,707	\$94,595		\$136,098	\$41,503	\$3,371,475	1
2	Related Party								2
3	Buildings:								3
4	Allocated from Mado Management LP	2018	171,589		39	4,400	4,400	30,798	4
5									5
6	Leasehold Improvements:								6
7	Allocated from Mado Management LP	2018	9,773		10	977	977	6,841	7
8	Allocated from Mado Management LP	2018	3,875		20	194	194	1,356	8
9	Allocated from Mado Management LP	2018	26,772	29,385	20	1,339	(28,046)	9,370	9
10	Allocated from Mado Management LP	2018	126,037		20	6,302	6,302	44,113	10
11	Allocated from Mado Management LP	2020	37,666		20	1,883	1,883	9,417	11
12	Allocated from Mado Management LP	2022	29,621		20	1,481	1,481	4,443	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)		\$5,070,040	\$123,980		\$152,674	\$28,694	\$3,477,814	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	\$11,872	\$	\$2,014	\$2,014	10	\$1,160	71
72	Current Year Purchases	8,254		1,651	1,651	10		72
73	Fully Depreciated Assets	531,747				10	531,747	73
74								74
75	TOTALS	\$551,873	\$	\$3,665	\$3,665		\$532,907	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 JEEP GRAND CHER	1998	\$24,457	\$	\$	\$	5	\$24,457	76
77		Sherman Dodge	2021	50,604				5	50,604	77
78										78
79										79
80	TOTALS			\$75,061	\$	\$	\$		\$75,061	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)	\$5,719,051	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$123,980	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$156,339	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$32,359	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,085,782	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	Cap report Desk Audit - 2010	\$105,150	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$105,150	\$	\$	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: 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:
- *

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: \$ 5,230
- 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.

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	\$

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)	\$			

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.)

12345678										
	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,373,007	\$ 2,406,165	1
2	Cash-Patient Deposits	70,096	70,096	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,009,364	1,009,364	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,252	31,252	6
7	Other Prepaid Expenses	11,787	11,787	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	63,270	63,270	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,558,776	\$ 3,591,934	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		233,740	13
14	Buildings, at Historical Cost		547,642	14
15	Leasehold Improvements, at Historical Cost	3,063,323	3,063,323	15
16	Equipment, at Historical Cost	602,470	602,470	16
17	Accumulated Depreciation (book methods)	(2,556,906)	(2,556,906)	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):	3,002,919	3,271,420	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,111,806	\$ 5,161,689	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,670,582	\$ 8,753,623	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,108,595	\$ 2,133,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,685	28,685	28
29	Short-Term Notes Payable	484,390	484,390	29
30	Accrued Salaries Payable	136,400	136,400	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,784	33,784	31
32	Accrued Real Estate Taxes(Sch.IX-B)		276,001	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	22,422	22,422	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,814,276	\$ 3,114,692	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,818,278	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)	\$	\$ 1,818,278	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,814,276	\$ 4,932,970	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,856,306	\$ 3,820,653	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,670,582	\$ 8,753,623	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,742,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,742,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,150,005	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	(35,939)	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)	\$ 2,114,066	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)	\$ 4,856,306	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mado Healthcare Douglas Park

0054106

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,388,839	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,388,839	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***	20,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,000	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Income	1,628,666	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,628,666	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,037,505	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,458,205	31
32	Health Care	2,160,951	32
33	General Administration	2,370,275	33
	B. Capital Expense		
34	Ownership	889,715	34
	C. Ancillary Expense		
35	Special Cost Centers	8,354	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,887,500	40
41	Income before Income Taxes (line 30 minus line 40)**	2,150,005	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,150,005	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 439,330.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	7,120,600.00	45
46	MMAI-Medicaid is the Primary Payer	816,129.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	12,780.00	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)	\$ 8,388,839	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,319	3,336	207,836	62.30	3
4	Licensed Practical Nurses	12,376	12,480	488,273	39.12	4
5	CNAs & Orderlies	3,964	4,105	275,556	67.13	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	3,064	3,086	77,336	25.06	9
10	Activity Assistants	4,205	4,248	73,095	17.21	10
11	Social Service Workers	39,375	39,568	539,169	13.63	11
12	Dietician			0		12
13	Food Service Supervisor	2,888	2,916	63,115	21.64	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	16,990	17,085	337,076	19.73	15
16	Dishwashers			0		16
17	Maintenance Workers	6,667	6,724	145,706	21.67	17
18	Housekeepers	5,815	5,938	274,317	46.20	18
19	Laundry	2,243	2,265	40,104	17.70	19
20	Administrator			145,399		20
21	Assistant Administrator	2,229	2,254	70,084	31.09	21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical	2,438	2,455	75,447	30.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,768	3,785	84,120	22.22	31
32	Other Health Care(specify)			0		32
33	Other(specify)	20,585	20,887	679,515	32.53	33
34	TOTAL (lines 1 - 33)	129,925	131,133	\$ 3,576,148 *	\$ 27.27	34

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	14,000	09-03	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				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	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,200	\$ 64,880	10-03	50
51	Licensed Practical Nurses	2,984	137,849	10-03	51
52	Certified Nurse Assistants/Aides	2	50	10-03	52
53	TOTAL (lines 50 - 52)	4,187	\$ 202,780		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Menier, Tina	ADMINISTRATOR-MADO		\$ 145,399	Workers' Compensation Insurance		\$ 34,757	IDPH License Fee	\$	
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	12,122	
				FICA Taxes		267,823	Health Care Worker Background Check		
				Employee Health Insurance		155,837	(Indicate # of checks performed)		
				Employee Meals		27,787	Patient Background Checks	5,189	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				401K - EMPLOYER'S SHARE		11,099	LICENSES, DUES & FEES	32,578	
				OTHER EMPL WELFARE EXPENSES		7,789	DONATIONS	50,010	
TOTAL (agree to Schedule V, line 17, col. 1)							Dues, Fees, Subscriptions & Promotions	2,742	
(List each licensed administrator separately.)							LICENSES, DUES & FEES	(74)	
B. Administrative - Other							Less: Public Relations Expense	(50,010)	
							PAC and Lobbying payments	()	
Description			Amount				All non-allowable advertising	()	
MANAGEMENT FEES			\$ 718,000						
MISC. CONSULTING FEE			45,500						
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 505,093			
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
LENOVO	DATA PROCESSING - EQUI		\$ 1,270			\$	Out-of-State Travel	\$	
PORCARO STOLAREK METE	DATA PROCESSING - MAINT		19,650						
NINJA ONE	DATA PROCESSING - MAINT		1,930						
ADP	DATA PROCESSING - MANAC		21,332				In-State Travel		
INOVALON PROVIDER, INC.	DATA PROCESSING - MANAC		7,650						
POINTCLICKCARE TECHNOLOG	DATA PROCESSING - MANAC		30,452						
BLUE HOST /ZOOM	DATA PROCESSING - MANAC		526						
LANER MUCHIN, LTD.	Legal		21,819				Seminar Expense		
H2HHS, INC. & Various	PROFESSIONAL FEES		91,490						
TOTAL (agree to Schedule V, line 19, column 3)							Entertainment Expense	()	
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V,		
			\$ 196,120	TOTAL		\$	line 24, col. 8)	\$	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? N/A
- (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 |
|------------------|--------------|
| | <u>N/A</u> |
| | |
| | |
| | <u>Total</u> |
- (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.
- | | |
|--|--------------|
| | <u>N/A</u> |
| | |
| | |
| | |
| | <u>Total</u> |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|--------------|
| | <u>N/A</u> |
| | |
| | |
| | |
| | <u>Total</u> |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 1,650 Line 10
- (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. \$
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. \$ 27,787 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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%
- 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 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.