

		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>0054130</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>Mado Healthcare Old Town</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>1121 N Orleans St</u> <u>Chicago</u> <u>60610</u> Number City Zip Code																																		
County: <u>Cook</u>																																		
Telephone Number: <u>'(312)-943-4300</u> Fax # <u>(312)-943-4304</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>07/01/1969</u>		<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>Rob Schlicht</u> <u>Director</u></td></tr><tr><td>(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee, WI 53226</u></td></tr><tr><td>(Telephone) <u>(414) 431-9335</u> Fax # <u>(414) 431-9335</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>Rob Schlicht</u> <u>Director</u>	(Firm Name & Address) <u>Wipfli LLP</u> <u>10000 Innovation Drive, Suite 250, Milwaukee, WI 53226</u>	(Telephone) <u>(414) 431-9335</u> Fax # <u>(414) 431-9335</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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<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☒</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☒</td><td>"Sub-S" Corp.</td></tr><tr><td>☐</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☒	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☒	"Sub-S" Corp.	☐	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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☐	Other _____																																	
In the event there are further questions about this report, please contact:																																		
Name: <u>Rob Schlicht</u> Telephone Number: <u>(414) 431-9335</u>																																		
Email Address: _____																																		

Facility Name & ID Number Mado Healthcare Old Town # 0054130 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	135	Intermediate (ICF)	135	49,275	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	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	3,132	34,365	6,090				243	43,830	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,132	34,365	6,090				243	43,830	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.95%

D. How many bed reserve days during this year were paid by the Department? 1,375 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1969

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL ☒ 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.

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	375,670	55,206	15,435	446,311		446,311		446,311			1
2	Food Purchase		328,253		328,253	(22,780)	305,473		305,473			2
3	Housekeeping	299,626	66,902	2,455	368,983		368,983		368,983			3
4	Laundry	1,169	54,126		55,295		55,295		55,295			4
5	Heat and Other Utilities			89,641	89,641		89,641	864	90,505			5
6	Maintenance	363,864		262,443	626,307		626,307	40,998	667,305			6
7	Other (specify):*							6,086	6,086			7
8	TOTAL General Services	1,040,329	504,487	369,974	1,914,790	(22,780)	1,892,010	47,948	1,939,958			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	973,615	54,309	259,421	1,287,345		1,287,345		1,287,345			10
10a	Therapy											10a
11	Activities	177,301	50,340		227,641		227,641		227,641			11
12	Social Services	375,362	3,803	46,827	425,992		425,992		425,992			12
13	CNA Training											13
14	Program Transportation		558	7,933	8,491		8,491	32	8,523			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,526,278	109,010	328,181	1,963,469		1,963,469	32	1,963,501			16
	C. General Administration											
17	Administrative			757,166	757,166		757,166	(583,712)	173,454			17
18	Directors Fees											18
19	Professional Services			167,727	167,727		167,727	7,069	174,796			19
20	Dues, Fees, Subscriptions & Promotions			79,552	79,552		79,552	(45,683)	33,869			20
21	Clerical & General Office Expenses	121,123	14,204	138,209	273,536		273,536	364,412	637,948			21
22	Employee Benefits & Payroll Taxes			382,812	382,812	22,780	405,592		405,592			22
23	Inservice Training & Education											23
24	Travel and Seminar			776	776		776	11,917	12,693			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			308,017	308,017		308,017		308,017			26
27	Other (specify):*							61,695	61,695			27
28	TOTAL General Administration	121,123	14,204	1,834,259	1,969,586	22,780	1,992,366	(184,302)	1,808,064			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,687,730	627,701	2,532,414	5,847,845		5,847,845	(136,322)	5,711,523			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			41,058	41,058		41,058	44,117	85,175			30
31	Amortization of Pre-Op. & Org.			472	472		472		472			31
32	Interest			16,528	16,528		16,528	134,853	151,381			32
33	Real Estate Taxes			247,044	247,044		247,044	7,427	254,471			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			5,173	5,173		5,173		5,173			35
36	Other (specify):*											36
37	TOTAL Ownership			766,275	766,275		766,275	(269,603)	496,672			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):*			16,011	16,011		16,011	(16,011)				43
44	TOTAL Special Cost Centers			16,011	16,011		16,011	(16,011)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,687,730	627,701	3,314,700	6,630,131		6,630,131	(421,936)	6,208,195			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	16,320	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				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	(11,908)	21		19
20	Contributions	(38,000)	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	(18,775)	21		24
25	Fund Raising, Advertising and Promotional	(10,277)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(811)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(17,303)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,754)		\$	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)	(291,909)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (291,909)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (372,663)		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			2
3	TRAFFIC VIOLATIONS	(2,553)	21	3
4	CIGARETTE PURCHASES	(150)	21	4
5	LEGAL FEES	(16,011)	43	5
6	Annual Report	(11,103)	19	6
7	MANAGEMENT FEES	(47,747)	17	7
8	TRUST FEES	(248)	21	8
9	LICENSES & FEES	(33)	20	9
10	LEGAL FEES	(1,320)	19	10
11	Capitalized R&M	0	0	11
12	Real estate tax	10,250	6	12
13		2,339	33	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(66,576)		49

Summary A

12/31/2025

[illegible]

Summary B

Facility Name & ID Number

0054130

01/01/2025

12/31/2025

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

[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	\$ 456,000	Long Term Care LP		\$	(456,000)	1
2	V	32	Interest	16,528	Long Term Care LP		147,263	130,735	2
3	V	33	REAL ESTATE TAX	247,044	Long Term Care LP		238,289	(8,755)	3
4	V	30	DEPRECIATIONS		Long Term Care LP		14,318	14,318	4
5	V	17	MANAGEMENT FEES		Long Term Care LP		47,747	47,747	5
6	V	21	TRUST FEES		Long Term Care LP		248	248	6
7	V	20	LICENSES & FEES		Long Term Care LP		33	33	7
8	V	19	LEGAL FEES		Long Term Care LP		1,320	1,320	8
9	V	19	OFFICE SUPPLIES		Long Term Care LP		35	35	9
10	V	19	PROFESSIONAL FEES		Long Term Care LP		10,061	10,061	10
11	V	21	BANK CHARGES		Long Term Care LP		14	14	11
12	V								12
13	V								13
14	Total			\$ 719,572			\$ 459,328	\$ * (260,244)	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		\$ 864	\$ 864	15
16	V	6	Maintenance		MADO MGMT. LP		30,748	30,748	16
17	V	7	Maintenance (other)		MADO MGMT. LP		6,086	6,086	17
18	V	14	Program Transportation		MADO MGMT. LP		32	32	18
19	V	17	Administrative		MADO MGMT. LP		1,592	1,592	19
20	V	19	Professional Services		MADO MGMT. LP		8,076	8,076	20
21	V	20	Dues, Fees, Subscriptions & Promotions		MADO MGMT. LP		2,594	2,594	21
22	V	21	Clerical & General Office Expenses		MADO MGMT. LP		398,595	398,595	22
23	V	24	Travel and Seminar		MADO MGMT. LP		11,917	11,917	23
24	V	27	Admin Others		MADO MGMT. LP		31,439	31,439	24
25	V	30	Depreciation		MADO MGMT. LP		13,479	13,479	25
26	V	32	Interest		MADO MGMT. LP		4,118	4,118	26
27	V	33	Real Estate Taxes		MADO MGMT. LP		13,843	13,843	27
28	V				MADO MGMT. LP				28
29	V								29
30	V	17	MANAGEMENT FEES	636,000	MADO MGMT. LP			(636,000)	30
31	V								31
32	V	17	SALARY-P. O'BRIEN		MADO MGMT. LP		50,696	50,696	32
33	V	27	EMP. BEN.-P. O'BRIEN		MADO MGMT. LP		9,085	9,085	33
34	V								34
35	V	17	ADMINISTRATOR SALARY	121,166	MADO MGMT. LP		121,166		35
36	V								36
37	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		21,171	21,171	37
38	V								38
39	Total			\$ 757,166			\$ 725,501	\$ * (31,665)	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 OUTSIDE LABOR	\$ 113,947	MADO LLC		\$ 113,947	\$	15
16	V	12	SOCIAL SERVICE OUTSIDE LABOR	46,827	MADO LLC		46,827		16
17	V	01	DIETARY OUTSIDE LABOR	15,435	MADO LLC		15,435		17
18	V	06	MAINTENANCE O/S LABOR	136,451	MADO LLC		136,451		18
19	V	21	OFFICE SALARY O/S LABOR	63,380	MADO LLC		63,380		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			\$ 376,040			\$ 376,040	\$ *	39

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

STATE OF ILLINOIS				Ownership Listing-1				
Mado Healthcare Old Town								
ID#		0054130						
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 DESCENDANT 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		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Mado Healthcare - Uptown	Chicago			Long Term Care LP	Chicago	Building Co.	1
2	Mado Healthcare - Buena Park	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

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	Administrative	1.10%	See Attached	11.66	0.25	Alloc Salary	\$ 50,696	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	\$ 50,696		13

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

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

Facility Name & ID Number Mado Healthcare Old Town # 0054130 Report Period Beginning: 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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	PATIENT DAYS	165,232	4	\$ 3,259	\$	43,830	\$ 864	1
2	6	Maintenance	PATIENT DAYS	165,232	4	115,914		43,830	30,748	2
3	7	Maintenance (other)	PATIENT DAYS	165,232	4	22,944		43,830	6,086	3
4	14	Program Transportation	PATIENT DAYS	165,232	4	121		43,830	32	4
5	17	Administrative	PATIENT DAYS	165,232	4	6,001		43,830	1,592	5
6	19	Professional Services	PATIENT DAYS	165,232	4	30,446		43,830	8,076	6
7	20	Dues, Fees, Subscriptions & Prom	PATIENT DAYS	165,232	4	9,779		43,830	2,594	7
8	21	Clerical & General Office Expens	PATIENT DAYS	165,232	4	1,502,638		43,830	398,595	8
9	24	Travel and Seminar	PATIENT DAYS	165,232	4	44,926		43,830	11,917	9
10	27	Admin Others	PATIENT DAYS	165,232	4	118,520		43,830	31,439	10
11	30	Depreciation	PATIENT DAYS	165,232	4	50,814		43,830	13,479	11
12	32	Interest	PATIENT DAYS	165,232	4	15,524		43,830	4,118	12
13	33	Real Estate Taxes	PATIENT DAYS	165,232	4	52,184		43,830	13,843	13
14										14
15										15
16										16
17	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	4	200,000	200,000	12	50,696	17
18	17	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	4	35,840		12	9,085	18
19										19
20	17	Administrator Salary	Direct Allocation							20
21										21
22	27	Gen Admin - Emp Ben	Direct Allocation		3	59,759				22
23										23
24										24
25	TOTALS					\$ 2,268,669	\$ 200,000		\$ 583,164	25

Facility Name & ID Number Mado Healthcare Old Town # 0054130 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			\$	\$		\$ 113,947	1
2	12	Social Services Outside labor(O/L)	Direct						46,827	2
3	01	Dietary Outside labor(O/L)	Direct						15,435	3
4	06	Maintenance Outside labor(O/L)	Direct						136,451	4
5	21	Office Outside labor(O/L)	Direct						63,380	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					\$	\$		\$ 376,040	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			\$	1,890,395			\$	147,263	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Parkway Bank		X	Line of Credit								8,661	6
7	Signature Bank		X	Line of Credit								7,868	7
8													8
9	TOTAL Facility Related						\$	1,890,395			\$	163,792	9
	B. Non-Facility Related*												
10	Allocated from Mado Mgmt	X										4,118	10
11	Interest Income		X										11
12	Interest Income - Bldg Co.		X									(16,528)	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(12,410)	14
15	TOTALS (line 9+line14)						\$	1,890,395			\$	151,382	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

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.		\$	268,242	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.)				\$	260,887	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(7,355)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	261,826	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.				\$		6
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.				\$	254,471	7
Assessed Value from Real Estate Tax Bill: 2024 8						
Real Estate Tax Bill for Calendar Year: 2020 190,315 9						
2021 180,191 10						
2022 227,432 11						
2023 247,006 12						
2024 247,006 13						
2025 Accrual = 247006*1.06 = \$ 261826						
Allocated from Mado Mgmt LP = 13843						
				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 Old Town COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054130

CONTACT PERSON REGARDING THIS REPORT Steven N. Lavenda

TELEPHONE (847)262-6300 FAX #: (847)262-6300

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. 17-04-401-001	1147 N. Orleans	\$ 29,232.05	\$ 29,232.05
2. 17-04-401-004	1145 N. Orleans	\$ 7,308.20	\$ 7,308.20
3. 17-04-401-005	1143 N. Orleans	\$ 7,599.95	\$ 7,599.95
4. 17-04-401-006	1141 N. Orleans	\$ 8,042.34	\$ 8,042.34
5. 17-04-401-007	1139 N. Orleans	\$ 8,624.18	\$ 8,624.18
6. 17-04-401-008	1137 N. Orleans	\$ 9,502.36	\$ 9,502.36
7. 17-04-401-009	1133 N. Orleans	\$ 10,525.79	\$ 10,525.79
8. 17-04-401-010	1131 N. Orleans	\$ 36,087.07	\$ 36,087.07
9. 17-04-409-009	1121 N. Orleans	\$ 130,121.69	\$ 130,121.69
10. See Attached	Home Office Allocation	\$ 52,148.00	\$ 13,843.00
TOTALS		\$ 299,191.63	\$ 260,886.63

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

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? (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).

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

Report Period Beginning:

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various		1975		9,723		20			9,723	9	
10	Various		1976		6,706		20			6,706	10	
11	Various		1977		46,090		20			46,090	11	
12	Various		1978		21,593		20			21,593	12	
13	Various		1979		23,565		20			23,565	13	
14	Various		1982		4,014		20			4,014	14	
15	Various		1983		5,200		20			5,200	15	
16	Various		1984		4,952		20			4,952	16	
17	Various		1985		9,766		20			9,766	17	
18	Various		1986		36,773		20			36,773	18	
19	Various		1987		7,315		20			7,315	19	
20	Various		1988		6,455		20			6,455	20	
21	Various		1989		2,400		20			2,400	21	
22	Various		1990		7,500		20			7,500	22	
23	Various		1991		19,058		20			19,058	23	
24	Various		1992		103,932		20			103,932	24	
25	Various		1993		50,916		20			50,916	25	
26	Various		1994		115,474		20			115,474	26	
27	Various		1995		17,694		20			17,694	27	
28	Various		1996		67,919		20			67,919	28	
29	Various		1997		84,459		20			84,459	29	
30	Various		1998		71,615		20			71,615	30	
31	Various		1999		18,526		20			18,526	31	
32	Various		2000		53,714		20			53,714	32	
33	Various		2001		130,871		20			130,871	33	
34	Various		2002		139,537		20			139,537	34	
35	Various		2003		72,824		20			72,824	35	
36	Various		2004		137,144		20			137,144	36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mado Healthcare Old Town

0054130

Report Period Beginning:

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	2005	\$ 135,533	\$	20	\$	\$	\$ 135,532	37
38	Various	2006	124,265		20			124,265	38
39	Various	2007	37,299		20			37,299	39
40	Various	2008	130,612		20	6,531	6,531	111,019	40
41	Various	2009	104,458		20	5,223	5,223	83,566	41
42	Various	2010	26,496		20	1,325	1,325	19,871	42
43	Various	2011	31,723		20	1,586	1,586	22,207	43
44	Various	2012	9,100		20	455	455	5,915	44
45	Various	2013	78,636		20	3,933	3,933	47,172	45
46	Various	2014	38,816		20	1,941	1,941	21,347	46
47	Various	2015	56,325		20	2,816	2,816	28,165	47
48	Various	2016	30,939		20	1,547	1,547	13,922	48
49	Various	2017	48,565		20	2,429	2,429	19,417	49
50	Various	2018	7,600		20	380	380	2,660	50
51	Various	2019	13,890		20	695	695	4,160	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 12H & 12I)		357,641	27,797		14,625	(13,172)	83,514	68
69	Financial Statement Depreciation			41,058			(41,058)		69
70	TOTAL (lines 4 thru 69)		\$ 2,507,633	\$ 68,855		\$ 43,486	\$ (25,369)	\$ 2,035,766	70

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

Facility Name & ID Number Mado Healthcare Old Town

0054130

Report Period Beginning:

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		\$ 2,507,633	\$ 68,855		\$ 43,486	\$ (25,369)	\$ 2,035,766	1
2	Room 409 Renovation-Radiators,Flooring, New Doors,Drywall-La	2020	27,017		20	1,351	1,351	6,754	2
3	Radiators	2020	3,700		20	185	185	925	3
4	5 Smoke Detectors - Rooms 207,307,309,401,407	2021	5,700		20	285	285	1,140	4
5	Passenger Elevator - Replacement Of Collapsible Elevator Car Ga	2022	3,840		20	192	192	576	5
6	Replace Steam Traps & Radiator Valves	2022	2,693		20	135	135	404	6
7	Generator Repairs - New Transfer Switch Controller	2022	3,997		20	200	200	600	7
8	Repair Entrance Door Opening - New Transom Frame	2023	2,825		20	141	141	283	8
9	Fire Sprinkler System Repair - New Cotrol Valve	2023	3,005		20	150	150	301	9
10	Fire Sprinkler Kitchen System - New Range Guard Tank	2023	2,800		20	140	140	280	10
11	Crack Seal, Seal Coating, Striping Of Parking Lot	2023	8,350		20	418	418	835	11
12	REMOVED OLD AND INSTALLED NEW KITCHEN EXHAUS	2024	5,200		20	260	260	260	12
13	MAKE UP FEED TANK- DISCONNECT & INSTALLED TANK	2024	20,295		20	1,015	1,015	1,015	13
14	CONFERENCE, LOBBY AND FRONT DESK RENOVATION	2024	149,652		20	7,483	7,483	7,483	14
15	ADVANCED FIRE & SECURITY	2024	1,199		20	60	60	60	15
16	ALL-TYPES ELEVATORS	2024	5,635		20	282	282	282	16
17	ARDMORE GLASS & MIRROR CO.INC.	2024	1,645		20	82	82	82	17
18	DOOR SYSTEMS	2024	4,650		20	233	233	233	18
19	EDWARD TUCKPOINTING	2024	4,180		20	209	209	209	19
20	HOME DEPOT CREDIT SERVICES	2024	1,978		20	99	99	99	20
21	HOME DEPOT CREDIT SERVICES	2024	1,890		20	95	95	95	21
22	HOME DEPOT CREDIT SERVICES	2024	3,547		20	177	177	177	22
23	HOME DEPOT CREDIT SERVICES	2024	2,043		20	102	102	102	23
24	JOB 1 FIRE PROTECTION SER.INC.	2024	2,740		20	137	137	137	24
25	JOB 1 FIRE PROTECTION SER.INC.	2024	4,122		20	206	206	206	25
26	JOB 1 FIRE PROTECTION SER.INC.	2024	2,695		20	135	135	135	26
27	LUCAS MECHANICAL LLC	2024	2,055		20	103	103	103	27
28	LUCAS MECHANICAL LLC	2024	1,330		20	67	67	67	28
29	LUCAS MECHANICAL LLC	2024	1,090		20	55	55	55	29
30	PHOENIX INDUSTRIAL CLEANING	2024	1,160		20	58	58	58	30
31	QUALITY WINDOWS REPAIR	2024	1,950		20	98	98	98	31
32	R&M ELECTRICAL SERVICES, INC	2024	1,450		20	73	73	73	32
33	RYSZARD MATUSZEWSKI	2024	1,076		20	54	54	54	33
34	TOTAL (lines 1 thru 33)		\$ 2,793,141	\$ 68,855		\$ 57,761	\$ (11,094)	\$ 2,058,942	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward	\$ 2,793,141	\$ 68,855		\$ 57,761	\$ (11,094)	\$ 2,058,942	1
2	PUMP	20255,500		20	275	275	141	2
3	SLIDE GATE MOTOR	20255,750		20	288	288	147	3
4	AP HEATING & A/C INC.	20255,500		20	275	275	275	4
5	CAPITAL ONE TRADE CREDIT	20253,418		20	171	171	171	5
6	CAPITAL ONE TRADE CREDIT	20253,798		20	190	190	190	6
7	HOME DEPOT CREDIT SERVICES	20253,559		20	178	178	178	7
8	INNOVATIVE WINDOW CLEANING INC	20253,350		20	168	168	168	8
9	KG DOORS & GATES	20254,750		20	238	238	238	9
10	SUNBELT RENTAL	20253,120		20	156	156	156	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)	\$ 2,831,886	\$ 68,855		\$ 59,699	\$ (9,156)	\$ 2,060,605	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$2,831,886	\$68,855		\$59,699	\$ (9,156)	\$2,060,605	1
2									2
3	Allocated from Mado Management LP	2018	151,400		39	3,882	3,882	24,374	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Mado Management LP	2018	8,623		10	862	862	5,281	9
10	Allocated from Mado Management LP	2018	3,419		20	171	171	1,069	10
11	Allocated from Mado Management LP	2018	23,622		20	1,181	1,181	7,382	11
12	Allocated from Mado Management LP	2018	111,208	27,797	20	5,560	(22,237)	34,752	12
13	Allocated from Mado Management LP	2020	33,234		20	1,662	1,662	7,339	13
14	Allocated from Mado Management LP	2022	26,135		20	1,307	1,307	3,317	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,189,527	\$96,652		\$74,324	\$ (22,328)	\$2,144,119	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$3,189,527	\$96,652		\$74,324	\$ (22,328)	\$2,144,119	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,189,527	\$96,652		\$74,324	\$ (22,328)	\$2,144,119	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	\$ 39,371	\$	\$ 6,008	\$ 6,008	10	\$ 5,371	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	391,123				10	391,123	73
74								74
75	TOTALS	\$ 430,494	\$	\$ 6,008	\$ 6,008		\$ 396,494	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	\$ 9,571	\$	\$	\$	5	\$ 9,571	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$ 9,571	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)	\$ 3,622,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,652	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,332	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,320)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,550,184	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES

☒NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy:

YES

NO

 Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

☒NO
16. Rental Amount for movable equipment: \$5,173Description:

(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	\$ 1,421,659	\$ 1,453,026	1
2	Cash-Patient Deposits	48,669	48,669	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	686,777	686,777	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,525	24,525	6
7	Other Prepaid Expenses	10,874	10,874	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	80,756	80,756	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,273,260	\$ 2,304,627	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		221,108	13
14	Buildings, at Historical Cost		518,046	14
15	Leasehold Improvements, at Historical Cost	2,211,066	2,211,066	15
16	Equipment, at Historical Cost	440,062	440,062	16
17	Accumulated Depreciation (book methods)	(1,994,131)	(1,994,131)	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):	2,279,174	2,533,163	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,936,171	\$ 3,929,314	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,209,431	\$ 6,233,941	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,487,400	\$ 1,503,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,823	26,823	28
29	Short-Term Notes Payable	142,070	142,070	29
30	Accrued Salaries Payable	101,823	23,269	30
31	Accrued Taxes Payable (excluding real estate taxes)	555	555	31
32	Accrued Real Estate Taxes(Sch.IX-B)		261,085	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,758,671	\$ 1,957,700	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,720,014	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	10,115	10,114	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,115	\$ 1,730,128	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,768,786	\$ 3,687,828	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,440,645	\$ 2,546,113	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,209,431	\$ 6,233,941	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,031,320	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,031,320	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,609,543	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	(1,200,218)	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)	\$ 409,325	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)	\$ 3,440,645	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mado Healthcare Old Town

0054130

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	\$ 7,209,989	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,209,989	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		1,029,685	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,029,685	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,239,674	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,914,790	31
32	Health Care	1,963,469	32
33	General Administration	1,969,586	33
	B. Capital Expense		
34	Ownership	766,275	34
	C. Ancillary Expense		
35	Special Cost Centers	16,011	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)*	\$ 6,630,131	40
41	Income before Income Taxes (line 30 minus line 40)**	1,609,543	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,609,543	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 517,423.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,650,033.00	45
46	MMAI-Medicaid is the Primary Payer	1,042,533.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		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)	\$ 7,209,989	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	725	748	27,071	36.19	3
4	Licensed Practical Nurses	11,297	11,388	397,819	34.93	4
5	CNAs & Orderlies	25,110	25,291	474,447	18.76	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	8,593	8,677	169,005	19.48	10
11	Social Service Workers	16,750	16,884	375,362	22.23	11
12	Dietician	18,932	19,124	375,670	19.64	12
13	Food Service Supervisor			0		13
14	Head Cook			0		14
15	Cook Helpers/Assistants			0		15
16	Dishwashers			0		16
17	Maintenance Workers	4,935	4,976	93,012	18.69	17
18	Housekeepers	15,444	15,593	299,626	19.22	18
19	Laundry	56	56	1,169	20.88	19
20	Administrator			0		20
21	Assistant Administrator			0		21
22	Other Administrative	2,070	2,087	61,212	29.33	22
23	Office Manager	2,402	2,421	59,911	24.75	23
24	Clerical			0		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	4,099	4,132	74,278	17.98	31
32	Other Health Care(specify)			0		32
33	Other(specify)	14,599	14,737	270,853	18.38	33
34	TOTAL (lines 1 - 33)	125,013	126,114	\$ 2,679,435 *	\$ 21.25	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	435	\$ 15,435	01-03	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	1,224	46,827	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,659	\$ 77,462		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	32	\$ 1,909	10-03	50
51	Licensed Practical Nurses	2,795	141,834	10-03	51
52	Certified Nurse Assistants/Aides	23	531	10-03	52
53	TOTAL (lines 50 - 52)	2,850	\$ 144,274		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
NameFunction%Amount	DescriptionAmount	DescriptionAmount
	Workers' Compensation Insurance\$25,060	IDPH License Fee\$
	Unemployment Compensation Insurance	Advertising: Employee Recruitment10,277
	FICA Taxes194,949	Health Care Worker Background Check(Indicate # of checks performed)
	Employee Health Insurance128,928	Patient Background Checks1,091
	Employee Meals22,780	
	Illinois Municipal Retirement Fund (IMRF)*	
	FUTA4,155	DONATIONS38,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)	SUTA18,753	LICENSES, DUES & FEES(75)
B. Administrative - Other	401K - EMPLOYER'S SHARE861	LICENSES & FEES30,217
	Other Employee Welfare10,106	Dues, Fees, Subscriptions & Promotions2,594
		Less: Public Relations Expense(38,000)
DescriptionAmount		PAC and Lobbying payments ()
Management Fees\$636,000		All non-allowable advertising(10,277)
Administrator - Mado121,166		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$405,592	TOTAL (agree to Sch. V, line 20, col. 8)\$33,827
C. Professional Services	E. Schedule of Non-Cash Compensation Paid to Owners or Employees	G. Schedule of Travel and Seminar**
Vendor/PayeeTypeAmount	DescriptionLine #Amount	DescriptionAmount
LENOVODATA PROCESSING - EQU7,435		Out-of-State Travel\$
PORCARO STOLAREK METEDATA PROCESSING - MAINT15,394		
NINJA ONEDATA PROCESSING - MAINT1,781		
ADPDATA PROCESSING - MANAC19,716		In-State Travel
INOVALON PROVIDER, INC.DATA PROCESSING - MANAC5,990		
POINTCLICKCARE TECHNOLOGDATA PROCESSING - MANAC25,034		
BLUE HOST /ZOOMDATA PROCESSING - MANAC634		
LANER MUCHIN, LTD.Legal11,103		Seminar Expense
H2HHS, INC. & VariousPROFESSIONAL FEES80,640		
		SAFE DINING ASSOCIATION776
		Travel and Seminar11,917
		Entertainment Expense ()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)	TOTAL\$	TOTAL (agree to Sch. V, line 24, col. 8)\$12,693

*** Attach copy of IMRF notifications**

****See instructions.**

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 |
|------------------|--------------|
| | <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. \$ 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. \$ 22,780 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? _____
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (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.