FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054130

Facility Name: MADO Healthcare - Old Town

Address: 1121 N. Orleans (Number) Chicago (City) 60610 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) CAMILLE B. LOCKHART, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	43,644	265		43,909	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,644	265		43,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.11%

D. How many bed reserve days during this year were paid by the Department?
NONE (Do not include bed reserve days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	298,483	26,687	7,133	332,303		332,303		332,303			1
2	Food Purchase		239,469		239,469	(28,736)	210,733		210,733			2
3	Housekeeping	136,879	35,306		172,185		172,185		172,185			3
4	Laundry	15,672	24,367		40,039		40,039		40,039			4
5	Heat and Other Utilities			83,096	83,096		83,096	1,265	84,361			5
6	Maintenance	93,634		111,676	205,310		205,310	(39,535)	165,775			6
7	Other (specify):*	199,855			199,855		199,855		199,855			7
8	TOTAL General Services	744,523	325,829	201,905	1,272,257	(28,736)	1,243,521	(38,270)	1,205,251			8
	B. Health Care and Programs											
9	Medical Director			9,150	9,150		9,150		9,150			9
10	Nursing and Medical Records	974,312	28,627	15,170	1,018,109		1,018,109		1,018,109			10
10a	Therapy											10a
11	Activities	74,149	40,581	9,076	123,806		123,806	(3,280)	120,526			11
12	Social Services	271,807	1,195	37,001	310,003		310,003	(720)	309,283			12
13	CNA Training											13
14	Program Transportation			4,968	4,968		4,968		4,968			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,320,268	70,403	75,365	1,466,036		1,466,036	(4,000)	1,462,036			16
	C. General Administration											
17	Administrative			622,875	622,875		622,875	(464,934)	157,941			17
18	Directors Fees											18
19	Professional Services			57,099	57,099		57,099	(2,233)	54,866			19
20	Dues, Fees, Subscriptions & Promotions			20,628	20,628		20,628	(2,181)	18,447			20
21	Clerical & General Office Expenses	82,832	30,511	33,929	147,272		147,272	289,132	436,404			21
22	Employee Benefits & Payroll Taxes			350,575	350,575	28,736	379,311		379,311			22
23	Inservice Training & Education			250	250		250		250			23
24	Travel and Seminar			12,805	12,805		12,805	(3,996)	8,809			24
25	Other Admin. Staff Transportation							1,226	1,226			25
26	Insurance-Prop.Liab.Malpractice			182,573	182,573		182,573	4,464	187,037			26
27	Other (specify):*							60,988	60,988			27
28	TOTAL General Administration	82,832	30,511	1,280,734	1,394,077	28,736	1,422,813	(117,534)	1,305,279			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,147,623	426,743	1,558,004	4,132,370		4,132,370	(159,804)	3,972,566			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MADO Healthcare - Old Town #0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			48,107	48,107		48,107	31,774	79,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,241	88,241		88,241	137,531	225,772			32
33	Real Estate Taxes							165,261	165,261			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			5,688	5,688		5,688		5,688			35
36	Other (specify):*											36
37	**TOTAL Ownership**			598,036	598,036		598,036	(121,434)	476,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		11,150		11,150		11,150		11,150			39
40	Barber and Beauty Shops			1,605	1,605		1,605		1,605			40
41	Coffee and Gift Shops		(380)		(380)		(380)	(918)	(1,298)			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		10,770	1,605	12,375		12,375	(918)	11,457			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,147,623	437,513	2,157,645	4,742,781		4,742,781	(282,156)	4,460,625			45

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(26,508)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,351)	21		18
19	Entertainment	(3,996)	24		19
20	Contributions	(71)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,060)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,588)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,810)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(35,527)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (86,911)		$	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)	(195,245)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (195,245)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (282,156)		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

STATE OF ILLINOIS **Page 5A**

MADO Healthcare - Old Town

ID# **0054130**

Report Period Beginning: **1/1/17**

Ending: **12/31/17**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (9,336)	21	1
2	VENDING INCOME	(1,298)	41	2
3	BANK CHARGES	(1,108)	21	3
4	MISC-CLIENT CLOTHING	(4,171)	21	4
5	ACTIVITY-CIGARETTES	(3,280)	11	5
6	SOCIAL SERVICES-CIGARETTES	(720)	12	6
7	CIGARETTE PURCHASES	380	41	7
8	CAPITALIZED R&M	(41,965)	6	8
9	ADJ TO S/L DEPR	25,971	30	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				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**	(35,527)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number MADO Healthcare - Old Town **#** 0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,265	0	0	0	0	0	0	0	0	1,265	5
6	Maintenance	(41,965)	0	2,430	0	0	0	0	0	0	0	0	(39,535)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(41,965)	0	3,695	0	0	0	0	0	0	0	0	(38,270)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,280)	0	0	0	0	0	0	0	0	0	0	(3,280)	11
12	Social Services	(720)	0	0	0	0	0	0	0	0	0	0	(720)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,000)	0	0	0	0	0	0	0	0	0	0	(4,000)	16
	C. General Administration													
17	Administrative	0	0	(464,934)	0	0	0	0	0	0	0	0	(464,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,060)	0	8,827	0	0	0	0	0	0	0	0	(2,233)	19
20	Fees, Subscriptions & Promotions	(2,588)	0	407	0	0	0	0	0	0	0	0	(2,181)	20
21	Clerical & General Office Expenses	(21,847)	0	310,979	0	0	0	0	0	0	0	0	289,132	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,996)	0	0	0	0	0	0	0	0	0	0	(3,996)	24
25	Other Admin. Staff Transportation	0	0	1,226	0	0	0	0	0	0	0	0	1,226	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,464	0	0	0	0	0	0	0	0	4,464	26
27	Other (specify):*	0	0	60,988	0	0	0	0	0	0	0	0	60,988	27
28	**TOTAL General Administration**	(39,491)	0	(78,043)	0	0	0	0	0	0	0	0	(117,534)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,456)	0	(74,348)	0	0	0	0	0	0	0	0	(159,804)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MADO Healthcare - Old Town **#** 0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	25,971	0	5,803	0	0	0	0	0	0	0	0	31,774	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,508)	150,833	13,206	0	0	0	0	0	0	0	0	137,531	32
33	Real Estate Taxes	0	159,896	5,365	0	0	0	0	0	0	0	0	165,261	33
34	Rent-Facility & Grounds	0	(456,000)	0	0	0	0	0	0	0	0	0	(456,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(537)	(145,271)	24,374	0	0	0	0	0	0	0	0	(121,434)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(918)	0	0	0	0	0	0	0	0	0	0	(918)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(918)	0	0	0	0	0	0	0	0	0	0	(918)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(86,911)	(145,271)	(49,974)	0	0	0	0	0	0	0	0	(282,156)	45

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 456,000	Long Term Care LP	100.00%	$	$ (456,000)	1
2	V	32	Interest		Long Term Care LP	100.00%	150,833	150,833	2
3	V	33	Real Estate Taxes		Long Term Care LP	100.00%	159,896	159,896	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 456,000			$ 310,729	$ * (145,271)	14

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Mado Management	100.00%	$ 1,265	$ 1,265	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	2,430	2,430	16
17	V	19	Professional Fees		Mado Management	100.00%	8,827	8,827	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	407	407	18
19	V	21	Clerical and General		Mado Management	100.00%	310,979	310,979	19
20	V	25	Auto Expense		Mado Management	100.00%	1,226	1,226	20
21	V	26	Insurance		Mado Management	100.00%	4,464	4,464	21
22	V	27	Employee Benefits		Mado Management	100.00%	38,301	38,301	22
23	V	30	Depreciation		Mado Management	100.00%	5,803	5,803	23
24	V	32	Interest		Mado Management	100.00%	13,206	13,206	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	5,365	5,365	25
26	V								26
27	V	17	Management Fees	536,000	Mado Management	100.00%		(536,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	60,216	60,216	29
30	V	27	Employee Benefits		Mado Management	100.00%	6,004	6,004	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	10,850	10,850	32
33	V	27	Employee Benefits		Mado Management	100.00%	16,683	16,683	33
34	V								34
35	V	17	Administrative Salary	86,875	Mado Management	100.00%	86,875		35
36	V								36
37	V								37
38	V								38
39	Total			$ 622,875			$ 572,901	$ * (49,974)	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 7,133	MADO LLC	100.00%	$ 7,133	$	15
16	V	6	Maintenance	1,360			1,360		16
17	V	10	Nursing	10,334			10,334		17
18	V	11	Activities	7,312			7,312		18
19	V	12	Social Services	37,000			37,000		19
20	V	21	Office	7,537			7,537		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			$ 70,676			$ 70,676	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	PETER O'BRIEN	OWNER	ADMINISTRATIV	100.00	SEE ATTACHED	11.5	19.23	ALLOC SAL	$ 60,216	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	$ 60,216		13

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MADO MANAGEMENT
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	174,994	4	$ 5,041	$	43,909	$ 1,265	1
2	6	Repair & Maintenance	Patient Days	174,994	4	9,685		43,909	2,430	2
3	19	Professional Fees	Patient Days	174,994	4	35,176		43,909	8,827	3
4	20	Dues and Subscriptions	Patient Days	174,994	4	1,623		43,909	407	4
5	21	Clerical and General	Patient Days	174,994	4	1,239,374	1,202,338	43,909	310,979	5
6	25	Auto Expense	Patient Days	174,994	4	4,886		43,909	1,226	6
7	26	Insurance	Patient Days	174,994	4	17,788		43,909	4,464	7
8	27	Employee Benefits	Patient Days	174,994	4	152,643		43,909	38,301	8
9	30	Depreciation	Patient Days	174,994	4	23,129		43,909	5,803	9
10	32	Interest	Patient Days	174,994	4	52,635		43,909	13,206	10
11	33	Real Estate Taxes	Patient Days	174,994	4	21,380		43,909	5,365	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked		4	240,000	240,000		60,216	13
14	27	Employee Benefits	Avg Hrs Worked		4	23,933			6,004	14
15										15
16	17	Administrative Salary	Direct Allocation			10,850	10,850		10,850	16
17	27	Employee Benefits	Direct Allocation			52,472			16,683	17
18										18
19	17	Administrative Salary	Direct Allocation			356,119	356,119		86,875	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,246,734	$ 1,809,307		$ 572,901	25

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	SIGNATURE BANK		X	MORTGAGE			$	$ 2,968,965			$ 150,833	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BRIDGEVIEW BANK		X	LINE OF CREDIT				205,000			23,718	6
7	SIGNATURE BANK		X	LINE OF CREDIT				584,240			38,015	7
8												8
9	TOTAL Facility Related						$	$ 3,758,205			$ 212,566	9
	B. Non-Facility Related*											
10	Nonallowable:											10
11	REAL ESTATE INTEREST										26,508	11
12	Allowable:											12
13	ALLOC FROM MADO MGT										13,206	13
14	TOTAL Non-Facility Related						$	$			$ 39,714	14
15	TOTALS (line 9+line14)						$	$ 3,758,205			$ 252,280	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 146,278	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.)		$ 157,635	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,357	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 153,904	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 165,261	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	109,820	8
	2013	122,968	9
	2014	125,446	10
	2015	139,313	11
	2016	152,270	12

Allocated from MADO Management = $5,365

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MADO Healthcare - Old Town COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054130

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-04-401-001		$ 19,200.69	$ 19,200.69
2.	17-04-401-004		$ 4,803.94	$ 4,803.94
3.	17-04-401-005		$ 4,977.78	$ 4,977.78
4.	17-04-401-006		$ 5,360.75	$ 5,360.75
5.	17-04-401-007		$ 5,678.77	$ 5,678.77
6.	17-04-401-008		$ 6,284.46	$ 6,284.46
7.	17-04-401-009		$ 6,959.80	$ 6,959.80
8.	17-04-401-010		$ 23,777.49	$ 23,777.49
9.	17-04-409-009		$ 75,226.63	$ 75,226.63
10.	17-04-204-012	Home Office(see attachment)	$ 21,379.66	$ 5,364.52
		TOTALS	$ 173,649.97	$ 157,634.83

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 a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MADO Healthcare - Old Town COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054130

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	135				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	9,723		20			9,723	9
10	Various			1976	6,706		20			6,706	10
11	Various			1977	46,090		20			46,090	11
12	Various			1978	21,593		20			21,593	12
13	Various			1979	23,565		20			23,565	13
14	Various			1982	4,014		20			3,981	14
15	Various			1983	5,200		20			5,200	15
16	Various			1984	4,952		20			4,344	16
17	Various			1985	9,766		20			9,548	17
18	Various			1986	36,773		20			30,774	18
19	Various			1987	7,315		20			7,315	19
20	Various			1988	6,455		20			6,455	20
21	Various			1989	2,400		20			2,400	21
22	Various			1990	7,500		20			6,209	22
23	Various			1991	19,058		20			19,058	23
24	Various			1992	103,932		20			103,932	24
25	Various - removed $3,565 per 2015 capital cost adj audit. Remvd. $11,000			1993	50,916		20			50,916	25
26	Various			1994	115,474		20			115,474	26
27	Various			1995	17,694		20			17,694	27
28	Various - removed $22,987 per 2015 capital cost adj audit			1996	67,919		20	424	424	67,919	28
29	Various - removed $6,643 per capital cost adj audit			1997	84,459		20	2,683	2,683	84,459	29
30	Various - - removed $2,470 & $1,800 per 2015 capital cost adj audit			1998	69,815		20	3,491	3,491	66,875	30
31	Various - removed $1,743 per 2015 capital cost adj audit			1999	20,326		20	1,016	1,016	18,276	31
32	Various			2000	53,714		20	2,686	2,686	47,345	32
33	Various - removed $798, $36,620 & $940 per capital cost adj audit			2001	130,073		20	6,504	6,504	96,750	33
34	Various - removed $3,593 per 2015 capital cost adj audit			2002	140,335		20			140,335	34
35	Various - removed $593 & $1,216 per capital cost adj audit			2003	72,824		20	3,641	3,641	51,879	35
36	Various			2004	137,143		20			137,143	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2005	$ 135,532	$	20	$ 6,777	$ 6,777	$ 98,313	37
38	Various	2006	124,264		20	6,213	6,213	115,620	38
39	Various	2007	37,298		20			37,298	39
40	Various - removed $1,421 disposal per client	2008	129,190		20	6,460	6,460	61,609	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,702,018	$		$ 39,895	$ 39,895	$ 1,514,797	70

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,702,018	$		$ 39,895	$ 39,895	$ 1,514,797	1
2	Gas Water Heater	2009	4,292		20	215	215	1,755	2
3	Grind Out Old Mortar	2009	72,900		20	3,645	3,645	32,805	3
4	Flooring & Shower Bases	2009	7,800		20	390	390	3,478	4
5	Resident Room Flooring	2009	5,154		20	258	258	2,235	5
6	2 Vacuum Condensate Tanks	2009	9,885		20	494	494	4,035	6
7	Asphalt Repairs	2010	4,427		20	221	221	1,824	7
8	Activity Room	2010	2,515		20	126	126	976	8
9	Intercom System Upgrade	2010	9,860		20	493	493	3,615	9
10	Install Fire Pump	2010	3,765		20	188	188	1,505	10
11	Elevator Motor Repair -changed year from 2011 to 2010 per 2015	2010	10,356		20	518	518	4,057	11
12	Hot Water Heater in Laundry Room	2011	4,677		20	234	234	1,599	12
13	Smoke Detectors-Resident Rooms	2011	12,900		20	645	645	4,515	13
14	Refurbished Gear Boxc for Elevator Machine	2011	10,280		20	514	514	3,298	14
15	Replacement of 33 Sprinkler Heads	2011	3,866		20	193	193	1,223	15
16	Tuckpointing of Roof-SW & ES Walls	2012	9,100		20	455	455	2,730	16
17	Furnished & Installed Pit Safety Switch & Wire - removed $2,514	2012							17
18	Stone Retaining Wall-East Courtyard	2013	4,800		20	240	240	1,200	18
19	First Floor Kitchen;Lobby;Hallway - New Fire Sprinklers and Sm	2013	12,870		20	644	644	3,268	19
20	Elevator Gate Operator	2013	3,659		20	183	183	915	20
21	Repaired Main Sewer Line	2013	3,600		20	180	180	900	21
22	First Floor - Addt'l Lintel Door Openings	2013	1,050		20	53	53	264	22
23	First Floor Bathroom, Kitchen & Living Area Materials for -	2013							23
24	Plumbing, Electrical, Flooring and Painting-removed $1,901 per 2	2013	26,982		20	1,349	1,349	6,935	24
25	First Floor - Labor for Demolition; Plumbing;Electrical;Tiling & I	2013	25,675		20	1,284	1,284	6,420	25
26	NRSG office, conf room, dev office (2)-replace all woodwork,	2014	19,949		20	997	997	3,988	26
27	new electrical wiring & fixtures; painting	2014							27
28	Supervisory/tamper switch fire alarm	2014	16,015		20	801	801	3,204	28
29	Repair fire sprinkler	2014	2,852		20	143	143	536	29
30	AP Heating System-stem radiators-bathroom, dining, kitchen & li	2015	6,900		20	345	345	949	30
31	Boiler-supply & install boiler - removed rebate of $6,824 per 2015	2015	38,006		20	1,900	1,900	5,225	31
32	Fire Sprinkler Repairs	2015	11,419		20	571	571	1,618	32
33	Electrical upgrades to Vault Room	2016	17,389		20	869	869	1,448	33
34	TOTAL (lines 1 thru 33)		$ 2,064,961	$		$ 58,043	$ 58,043	$ 1,621,316	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		$ 2,064,961	$		$ 58,043	$ 58,043	$ 1,621,316	1
2	Fire Troll Fire Pump Controller	2016	11,000		20	550	550	779	2
3	Roof-new aluminum ridge cap over Chapel	2016	2,550		10	255	255	425	3
4	Condensing Unit	2017	6,600		15	440	440	440	4
5	Tuckpointing, detailing & painting outside bricks	2017	16,500		20	619	619	619	5
6	Fence Wall tuckpointing, repair & power washing	2017	4,500		25	75	75	75	6
7	Replace Sprinkler Heads	2017	13,830		20	576	576	576	7
8	Fire Pump Repair	2017	3,000		20	125	125	125	8
9	Fire Sprinkler System Repair	2017	4,135		20	138	138	138	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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28									28
29									29
30									30
31				42,191			(42,191)		31
32	F/S Depreciation								32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,127,076	$ 42,191		$ 60,821	$ 18,630	$ 1,624,493	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,127,076	$ 42,191		$ 60,821	$ 18,630	$ 1,624,493	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	1988	52,009	1,944	35	1,486	(458)	32,691	4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management	1995	1,206		20			1,206	9
10	Allocated from Mado Management	1993	19,810		20			19,810	10
11	Allocated from Mado Management	2000	2,963		20	148	148	2,595	11
12	Allocated from Mado Management	2001	1,283		20	64	64	1,009	12
13	Allocated from Mado Management	2002	2,019		20			2,019	13
14		2004	568	6	20	28	22	378	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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 2,206,934	$ 44,141		$ 62,547	$ 18,406	$ 1,684,201	34

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 158,247	$ 5,916	$ 10,092	$ 4,176		$ 119,180	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	253,136					253,136	73
74								74
75	TOTALS	$ 411,383	$ 5,916	$ 10,092	$ 4,176		$ 372,316	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		86 OLDS	1990	$	$	$	$		$	76
77		Allocated from MADO Managem	2010	45,623	3,853	7,242	3,389	5	27,335	77
78										78
79										79
80	TOTALS			$ 45,623	$ 3,853	$ 7,242	$ 3,389		$ 27,335	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,665,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,971	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,083,852	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 5,688 Description: Postage Meter $2,214; Ice Machine $1,308; Copier $2,166
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				11,080		11,080	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB	39-02					70		70	12
13	Other (specify):									13
14	TOTAL			$		$	$ 11,150		$ 11,150	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.

STATE OF ILLINOIS

Facility Name & ID Number MADO Healthcare - Old Town **#** 0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,600	$	1
2	Cash-Patient Deposits	40,206		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	582,681		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,130		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Refund, Ex Acct, Deposit	20,578		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 662,195	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,005,902		15
16	Equipment, at Historical Cost	394,020		16
17	Accumulated Depreciation (book methods)	(1,529,651)		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):	991,018		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,861,289	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,523,484	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 463,326	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,321		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,049		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 510,696	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	789,240		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)**	$ 789,240	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,299,936	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,223,548	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,523,484	$	48

***(See instructions.)**

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,359,962	1
2	Restatements (describe):		2
3	**PRIOR PERIOD ADJUSTMENT**	(164,390)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,195,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	27,976	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 27,976	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,223,548	24 *

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,760,123	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,760,123	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	1,298	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)**	$ 1,298	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	9,336	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,336	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,770,757	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,272,257	31
32	Health Care	1,466,036	32
33	General Administration	1,394,077	33
	B. Capital Expense		
34	Ownership	598,036	34
	C. Ancillary Expense		
35	Special Cost Centers	12,375	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)***	$ 4,742,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	27,976	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 27,976	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,732,745	44
45	Private Pay - Net Inpatient Revenue	27,378	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,760,123	49

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

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

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,332	3,569	$ 119,082	$ 33.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,162	2,356	64,908	27.55	3
4	Licensed Practical Nurses	12,809	13,518	326,742	24.17	4
5	CNAs & Orderlies	31,128	33,489	394,186	11.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,598	1,846	24,555	13.30	9
10	Activity Assistants	3,987	4,480	49,594	11.07	10
11	Social Service Workers	13,510	14,707	271,807	18.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,838	20,180	251,641	12.47	15
16	Dishwashers	3,839	4,112	46,842	11.39	16
17	Maintenance Workers	6,808	7,414	93,634	12.63	17
18	Housekeepers	11,066	12,177	136,879	11.24	18
19	Laundry	1,249	1,416	15,672	11.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,373	1,571	38,653	24.60	22
23	Office Manager					23
24	Clerical	2,757	3,092	44,179	14.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,662	3,916	69,394	17.72	31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	16,345	17,411	199,855	11.48	33
34	TOTAL (lines 1 - 33)	134,463	145,254	$ 2,147,623 *	$ 14.79	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	MONTHLY	9,150	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	MONTHLY	250		38
39	Pharmacist Consultant	MONTHLY	950	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	37	1,764	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	$ 12,114		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	267	$ 10,334	10-3	50
51	Licensed Practical Nurses	104	3,636	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	371	$ 13,970		53

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.) $

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 536,000
ADMINISTRATOR - MADO	86,875

TOTAL (agree to Schedule V, line 17, col. 3) $ 622,875
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
BKD, LLP	ACCOUNTING	$ 10,852
LIFE SAFETY RESOURCES	CONSULTANT-BLDG INSP	2,173
PERSONNEL PLANNER	UNEMPLOY CONSULTANT	1,770
POWERHORN CONSULTING		573
	DATA PROCESSING	30,671
	LEGAL (NONALLOWABLE)	11,060

TOTAL (agree to Schedule V, line 19, column 3)
(For legal fee disclosure, see page 39 of instructions) $ 57,099

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,832
Unemployment Compensation Insurance	
FICA Taxes	212,279
Employee Health Insurance	80,500
Employee Meals	28,736
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	3,519
UNIFORMS	651
MISC	2,279
401K	515

TOTAL (agree to Schedule V, line 22, col.8) $ 379,311

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

Description	Line #	Amount
		$

TOTAL $

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 201	6,980
Advertising	2,588
Licenses, Dues & Fees	11,060
MADO ALLOCATION	407
Less: Public Relations Expense	( )
Non-allowable advertising	(2,588)
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $ 18,447

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,809
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $ 8,809

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

Facility Name & ID Number MADO Healthcare - Old Town # 0054130 Report Period Beginning: 1/1/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **566** Line **10-02**

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

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

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

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

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

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **28,736** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

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

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

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