FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0023770

Facility Name: MADO HEALTHCARE UPTOWN

Address: 4621 N RACINE AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 784-2300 **Fax #** (773-769-4621)

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1977

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

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

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

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

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 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	57	Skilled (SNF)	57	20,862	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,450	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,312	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	5,625		2,480	8,105	8
9	SNF/PED					9
10	ICF	35,363			35,363	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,988		2,480	43,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.97%

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 11/1/1978

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 6 and days of care provided 1,912

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	326,778	49,135	94,890	470,803		470,803		470,803			1
2	Food Purchase		245,519		245,519	(29,462)	216,057	(92,935)	123,122			2
3	Housekeeping	206,162	171,445	9,954	387,561		387,561	(128,347)	259,214			3
4	Laundry	81,621	74,816		156,437		156,437		156,437			4
5	Heat and Other Utilities			135,581	135,581		135,581	497	136,078			5
6	Maintenance	129,614		217,527	347,141		347,141	(16,877)	330,264			6
7	Other (specify):*	113,241			113,241		113,241		113,241			7
8	TOTAL General Services	857,416	540,915	457,952	1,856,283	(29,462)	1,826,821	(237,662)	1,589,159			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,459,502	275,328	335,922	3,070,752		3,070,752	(467,023)	2,603,729			10
10a	Therapy			340,920	340,920		340,920		340,920			10a
11	Activities	137,783	14,455	159	152,397		152,397		152,397			11
12	Social Services	370,835		16,861	387,696		387,696		387,696			12
13	CNA Training											13
14	Program Transportation			3,149	3,149		3,149		3,149			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,968,120	289,783	697,011	3,954,914		3,954,914	(467,023)	3,487,891			16
	C. General Administration											
17	Administrative			633,790	633,790		633,790	(485,940)	147,850			17
18	Directors Fees											18
19	Professional Services			197,523	197,523		197,523	(36,553)	160,970			19
20	Dues, Fees, Subscriptions & Promotions			17,174	17,174		17,174	773	17,947			20
21	Clerical & General Office Expenses	176,400	29,491	23,857	229,748		229,748	298,021	527,769			21
22	Employee Benefits & Payroll Taxes			674,376	674,376	29,462	703,838		703,838			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,773	2,773		2,773	(320)	2,453			24
25	Other Admin. Staff Transportation							654	654			25
26	Insurance-Prop.Liab.Malpractice			214,918	214,918		214,918	11,670	226,588			26
27	Other (specify):*							9,202	9,202			27
28	TOTAL General Administration	176,400	29,491	1,764,411	1,970,302	29,462	1,999,764	(202,493)	1,797,271			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,001,936	860,189	2,919,374	7,781,499		7,781,499	(907,178)	6,874,321			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 UPTOWN #0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,921	61,921		61,921	(3,069)	58,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,753	73,753		73,753	8,301	82,054			32
33	Real Estate Taxes							220,455	220,455			33
34	Rent-Facility & Grounds			204,000	204,000		204,000	(204,000)				34
35	Rent-Equipment & Vehicles			3,981	3,981		3,981		3,981			35
36	Other (specify):*			222	222		222		222			36
37	**TOTAL Ownership**			343,877	343,877		343,877	21,687	365,564			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,582		130,582		130,582		130,582			39
40	Barber and Beauty Shops			512	512		512		512			40
41	Coffee and Gift Shops		4,753		4,753		4,753	(4,753)				41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		135,335	512	135,847		135,847	(4,753)	131,094			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,001,936	995,524	3,263,763	8,261,223		8,261,223	(890,244)	7,370,979			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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Reference	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				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	(7,557)	21		18
19	Entertainment	(320)	24		19
20	Contributions	(3,100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(44,623)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,216)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(805,168)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (861,984)		$	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)	(28,260)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,260)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (890,244)		37

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

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

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

MADO HEALTHCARE UPTOWN

ID# 0023770

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (9,629)	21	1
2	BANK CHARGES	(2,699)	21	2
3	MISC-CLIENT CLOTHING		21	3
4	CIGARETTE PURCHASES	(4,753)	41	4
5	CAPITALIZED R&M	(15,414)	6	5
6	ADJ TO S/L DEPR	(18,032)	30	6
7	COVID FUNDS-DIETARY	(92,935)	2	7
8	COVID FUNDS-HKSP	(128,347)	3	8
9	COVID FUNDS-PLANT	(5,367)	6	9
10	COVID FUNDS-NURSING	(467,023)	10	10
11	COVID TAX CREDITS	(60,969)	27	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**	(805,168)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 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	(92,935)	0	0	0	0	0	0	0	0	0	0	(92,935)	2
3	Housekeeping	(128,347)	0	0	0	0	0	0	0	0	0	0	(128,347)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	497	0	0	0	0	0	0	0	0	497	5
6	Maintenance	(20,781)	0	3,904	0	0	0	0	0	0	0	0	(16,877)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(242,063)	0	4,401	0	0	0	0	0	0	0	0	(237,662)	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	(467,023)	0	0	0	0	0	0	0	0	0	0	(467,023)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	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**	(467,023)	0	0	0	0	0	0	0	0	0	0	(467,023)	16
	C. General Administration													
17	Administrative	0	0	(485,940)	0	0	0	0	0	0	0	0	(485,940)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,623)	0	8,070	0	0	0	0	0	0	0	0	(36,553)	19
20	Fees, Subscriptions & Promotions	0	0	773	0	0	0	0	0	0	0	0	773	20
21	Clerical & General Office Expenses	(24,201)	0	322,222	0	0	0	0	0	0	0	0	298,021	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	(320)	0	0	0	0	0	0	0	0	0	0	(320)	24
25	Other Admin. Staff Transportation	0	0	654	0	0	0	0	0	0	0	0	654	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,670	0	0	0	0	0	0	0	0	11,670	26
27	Other (specify):*	(60,969)	0	70,171	0	0	0	0	0	0	0	0	9,202	27
28	**TOTAL General Administration**	(130,113)	0	(72,380)	0	0	0	0	0	0	0	0	(202,493)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(839,199)	0	(67,979)	0	0	0	0	0	0	0	0	(907,178)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(18,032)	0	14,963	0	0	0	0	0	0	0	0	(3,069)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,301	0	0	0	0	0	0	0	0	8,301	32
33	Real Estate Taxes	0	211,457	8,998	0	0	0	0	0	0	0	0	220,455	33
34	Rent-Facility & Grounds	0	(204,000)	0	0	0	0	0	0	0	0	0	(204,000)	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**	(18,032)	7,457	32,262	0	0	0	0	0	0	0	0	21,687	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	(4,753)	0	0	0	0	0	0	0	0	0	0	(4,753)	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**	(4,753)	0	0	0	0	0	0	0	0	0	0	(4,753)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(861,984)	7,457	(35,717)	0	0	0	0	0	0	0	0	(890,244)	45

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 - OLD TOWN	CHICAGO	4621 Property LLC	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	RENT	$ 204,000	4621 PROPERTY LLC	100.00%	$	$ (204,000)	1
2	V	32	INTEREST						2
3	V	33	REAL ESTATE TAXES				211,457	211,457	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			$ 204,000			$ 211,457	$ * 7,457	14

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 497	$ 497	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	3,904	3,904	16
17	V	19	Professional Fees		Mado Management	100.00%	8,070	8,070	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	773	773	18
19	V	21	Clerical and General		Mado Management	100.00%	322,222	322,222	19
20	V	25	Auto Expense		Mado Management	100.00%	654	654	20
21	V	26	Insurance		Mado Management	100.00%	11,670	11,670	21
22	V	27	Employee Benefits		Mado Management	100.00%	45,009	45,009	22
23	V	30	Depreciation		Mado Management	100.00%	14,963	14,963	23
24	V	32	Interest		Mado Management	100.00%	8,301	8,301	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	8,998	8,998	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%	50,060	50,060	29
30	V	27	Employee Benefits		Mado Management	100.00%	6,754	6,754	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%			32
33	V	27	Employee Benefits		Mado Management	100.00%	18,408	18,408	33
34	V								34
35	V	17	Administrative Salary	97,790	Mado Management	100.00%	97,790		35
36	V								36
37	V								37
38	V								38
39	Total			$ 633,790			$ 598,073	$ * (35,717)	39

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	3	Dietary	$ 18,895	MADO LLC	100.00%	$ 18,895	$	15
16	V	6	Maintenance	71,430	MADO LLC		71,430		16
17	V	10	Nursing	89,622	MADO LLC		89,622		17
18	V	12	Social Services	13,221	MADO LLC		13,221		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			$ 193,168			$ 193,168	$ *	39

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	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	11.51	25.03	ALLOC SAL	$ 50,060	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,060		13

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

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	173,633	4	$ 1,984	$	43,468	$ 497	1
2	6	Repair & Maintenance	Patient Days	173,633	4	15,596		43,468	3,904	2
3	19	Professional Fees	Patient Days	173,633	4	32,235		43,468	8,070	3
4	20	Dues and Subscriptions	Patient Days	173,633	4	3,086		43,468	773	4
5	21	Clerical and General	Patient Days	173,633	4	1,287,117	1,242,587	43,468	322,222	5
6	25	Auto Expense	Patient Days	173,633	4	2,612		43,468	654	6
7	26	Insurance	Patient Days	173,633	4	46,614		43,468	11,670	7
8	27	Employee Benefits	Patient Days	173,633	4	179,790		43,468	45,009	8
9	30	Depreciation	Patient Days	173,633	4	59,771		43,468	14,963	9
10	32	Interest	Patient Days	173,633	4	33,160		43,468	8,301	10
11	33	Real Estate Taxes	Patient Days	173,633	4	35,943		43,468	8,998	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked			200,000	200,000		50,060	13
14	27	Employee Benefits	Avg Hrs Worked			26,984			6,754	14
15										15
16	17	Administrative Salary	Direct Allocation							16
17	27	Employee Benefits	Direct Allocation			74,027			18,408	17
18										18
19	17	Administrative Salary	Direct Allocation			428,308	428,308		97,790	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,427,227	$ 1,870,895		$ 598,073	25

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	PPP LOAN		4/16/20	$ 781,500	$ 781,500	4/16/22	1.0000	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST MIDWEST BANK		X					1,358,202			40,139	6
7	SIGNATURE BANK		X					535,505			33,614	7
8												8
9	TOTAL Facility Related						$ 781,500	$ 2,675,207			$ 73,753	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	ALLOC FROM MADO MGT											13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 781,500	$ 2,675,207			$ 73,753	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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 182,565	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.)		$ 189,388	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,823	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 189,410	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.		$ 196,233	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	127,931	8
	2016	139,766	9
	2017	150,294	10
	2018	166,020	11
	2019	180,390	12

Note: RE taxes paid includes $8,998 alloc from Mado Management

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MADO HEALTHCARE UPTOWN COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-207-006	Long Term Care Property	$ 128,523.24	$ 128,523.24
2.	14-17-207-012	Long Term Care Property	$ 1,772.61	$ 1,772.61
3.	14-17-207-013	Long Term Care Property	$ 10,991.56	$ 10,991.56
4.	14-17-207-014	4616 North Clifton (30%)	$ 18,656.28	$ 18,656.28
5.	14-17-207-019	Long Term Care Property	$ 20,446.63	$ 20,446.63
6.	17-04-204-012	Home Office	$ 35,942.86	$ 8,998.08
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 216,333.18	$ 189,388.40

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MADO HEALTHCARE UPTOWN COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,364 B. General Construction Type: Exterior _____ Frame Fire Retardent Number of Stories 4

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 [ ] 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	12,868	1984	$ 70,700	1
2					2
3	TOTALS	12,868		$ 70,700	3

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1984	1975	$ 1,494,824	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	541					541	9
10	Various			1979	38,105					38,105	10
11	Various			1981	22,244					22,244	11
12	Various			1982	12,527					12,527	12
13	Various			1983	5,530					5,530	13
14	Various			1984	25,958					25,958	14
15	Various			1985	10,641					10,641	15
16	Various			1986	13,635					13,635	16
17	Various			1987	65,231					65,231	17
18	Various			1988	30,395					30,395	18
19	Various			1990	115,949					115,949	19
20	Various			1991	10,000					10,000	20
21	Various			1992	22,069					22,069	21
22	Various			1993	18,217					18,217	22
23	Various			1994	12,220					12,220	23
24	Various			1995	109,219					109,219	24
25	Various			1996	28,361					28,361	25
26	Various			1997	69,848					69,848	26
27	Various			1998	56,951					56,951	27
28	Various			1999	93,038					93,038	28
29	Various			2000	84,672			2,226	2,226	84,672	29
30	Various			2001	72,394			3,620	3,620	70,952	30
31	Various			2002	121,688					121,688	31
32	Various			2003	57,379			2,869	2,869	50,199	32
33	Various			2004	89,609					89,609	33
34	Various			2005	31,058					31,058	34
35	Various			2006	23,468					23,468	35
36	Various			2007	10,166			508		6,787	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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	$ 18,781	$	20	$ 939	$ 939	$ 11,852	37
38	Replace Fire Doors	2009	3,772		20	189	189	2,156	38
39	Electrical Work In The Courtyard	2009	7,185		20	359	359	4,159	39
40	Electric Lock For Pedestrian Gate	2009	2,584		20	129	129	1,495	40
41	Brick Patio & Retaining Wall	2009	4,100		20	205	205	2,375	41
42	Repairs To Air Conditioning System	2009	2,685		20	134	134	1,520	42
43	Condensing Motor Fan	2009	4,433		20	222	222	2,552	43
44	Fire Alarm Wiring	2009	3,453		20	173	173	2,046	44
45	Therapy - Whirlpool Tub	2010	8,437		20	422	422	4,325	45
46	Furnish & Install Water Heater	2010	9,735		20	487	487	5,356	46
47	Sprinkler Heads	2010	4,769		20	238	238	2,540	47
48	Electrical Work - Elevator	2010	16,786		20	839	839	8,880	48
49	Electrical Work	2010	9,935		20	497	497	5,176	49
50	Cold Water Pressure Pump	2011	3,785		20	189	189	1,764	50
51	Fire Escape Improvement Per Idph Requirement	2011	17,595		20	880	880	8,726	51
52	Replaced Burned Wire, Filters For Two Compressors	2011	3,665		20	183	183	1,754	52
53	20 Ton Semi-Hermetic Reciprocating Compressor	2012	13,730		20	687	687	5,725	53
54	Bathroom Renovation (Ceiling, Electrical, Plumbing, Drywall, Flo	2012	8,570		20	429	429	3,468	54
55	Install New Dampers	2012	3,370		20	169	169	1,366	55
56	Sealed Wall Cracks; Rebuilt Damage Part Wall	2012	3,850		20	193	193	1,737	56
57	Installed New Valve And Drained Line	2012	4,654		20	233	233	2,097	57
58	Fire Sprinkler Repairs	2012	5,859		20	293	293	2,637	58
59	Fire Alarm Repairs	2012	3,762		20	188	188	1,692	59
60	Furnished And Installed Heating Elements For Water Heater Boo	2012	2,663		20	133	133	1,197	60
61	Replaced Armaflex Insulation	2012	3,546		20	177	177	1,593	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,917,641	$		$ 17,810	$ 17,302	$ 1,327,298	70

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,917,641	$		$ 17,810	$ 17,810	$ 1,327,298	1
2									2
3	Bathrooms-2nd-4th floor north - drywall, floors, fixtures, painting	2013	31,539		20	1,577	1,577	11,073	3
4	Asphalt Resurface	2013	12,500		8	1,563	1,563	11,332	4
5	Repaired South Passenger Elevator	2013	4,021		20	201	201	1,541	5
6	Repaired Mop Sink	2013	2,500		20	125	125	885	6
7	Install New 50 HP 230 Volt Pump Motor	2013	3,039		15	203	203	1,438	7
8	Excavated 25 Feet for Washing machine Line	2013	4,300		25	172	172	1,261	8
9	Repaired Fire Alarm System	2013	2,509		10	251	251	2,008	9
10	Tamper Panel Fire Detection System	2014	15,800		10	1,580	1,580	11,060	10
11	Steam Boiler	2014	34,860		20	1,743	1,743	11,765	11
12	Steam Compressor	2014	19,670		20	984	984	6,478	12
13	Bathrooms-2nd-5th floor south - materials and labor to replace	2014	65,876		20	3,294	3,294	20,039	13
14	walls, ceilings, floors, electrical & plumbing, fixtures; painting								14
15	Elevator repair-Hydraulic valve	2014	2,991		20	150	150	913	15
16	Elevator repair-Upgrades	2015	15,740		20	787	787	4,722	16
17	Elevator repair-Upgrades	2015	47,600		20	2,380	2,380	13,883	17
18	1st floor bathroom materials-electrical, floors, fixtures, drywall, pa	2015	2,713		20	136	136	691	18
19	Warehouse, laundry, 1st flr bthrm materials-electrical, floors, fixtu	2015	3,398		20	170	170	850	19
20	Repaired hydraulic pistons - south elevator	2015	3,095		20	155	155	827	20
21	#1 & 2 Elevators-Wiring. Furnish & install 2 emergency telephone	2015	2,561		20	128	128	661	21
22	Kitchen Ventilation Fan	2016	3,000		20	150	150	725	22
23	Elevator-Replace car sill, new gibs and hangers	2016	2,969		20	148	148	728	23
24	Elevator-Replace Hydraulic valve & oil	2016	4,419		20	221	221	1,068	24
25	Elevator-Repairs to North & South	2016	7,320		20	366	366	1,495	25
26	Elevator Repairs-#1 & #2	2017	2,793		20	140	140	513	26
27	Elevator Repairs-#2	2017	8,350		20	418	418	1,254	27
28	Replaced 3 steam traps	2017	3,462		20	173	173	634	28
29	A/C Repair inc new fan motor, fan blade & hub adapter	2019	7,177		20	359	359	509	29
30	Boiler Repair	2019	6,440		20	322	322	376	30
31	16 Fire Sprinkler System Repair & Fire Pump Repack	2019	3,290		20	165	165	316	31
32	Plumbing-8 RPZ's furnished & installed; double check valve	2019	9,925		20	496	496	744	32
33	Building Generator-Install Starter Upgrades	2020	5,216		20	22	22	22	33
34	TOTAL (lines 1 thru 33)		$ 3,256,714	$		$ 36,389	$ 36,389	$ 1,437,108	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,256,714	$		$ 36,389	$ 36,389	$ 1,437,108	1
2	3 Wall Showers	2020	2,900		10	24	24	24	2
3	Kohler Natural Gas Generator	2020	31,370		20	784	784	784	3
4	Transfer Switch/Control Board Replacement	2020	8,860		15	246	246	246	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	F/S Depreciation			17,965			(17,965)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,299,844	$ 17,965		$ 37,443	$ 19,478	$ 1,438,162	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,299,844	$ 17,965		$ 37,443	$ 19,478	$ 1,438,162	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	2018	149,519	3,834	39	3,834		8,626	4
5									5
6									6
7									7
8	Building Improvements								8
9	Allocated from Mado Management	2018	8,516	851	10	851		1,915	9
10	Allocated from Mado Management	2018	3,376	169	20	169		380	10
11	Allocated from Mado Management	2018	23,328	1,166	20	1,166		2,625	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	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)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,484,583	$ 23,985		$ 43,463	$ 19,478	$ 1,451,708	34

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 125,142	$ 43,956	$ 6,100	$ (37,856)		$ 123,944	71
72	Current Year Purchases	15,821		346	346		346	72
73	Fully Depreciated Assets	251,747						73
74								74
75	TOTALS	$ 392,710	$ 43,956	$ 6,446	$ (37,510)		$ 124,290	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		Allocated from MADO Mgt	Various	$ 62,740	$ 8,943	$ 8,943	$	5	$ 46,625	76
77										77
78										78
79										79
80	TOTALS			$ 62,740	$ 8,943	$ 8,943	$		$ 46,625	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)	$ 4,010,733	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 76,884	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 58,852	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,032)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,622,623	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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 3,981 Description: Icemaker $1,177; Copier $2,804
(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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-03	hrs	$	1,087	$ 103,237	$	1,087	$ 103,237	1
2	Licensed Speech and Language Development Therapist	10-03	hrs		809	84,177		809	84,177	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-03	hrs		1,633	153,506		1,633	153,506	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				83,277		83,277	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-ray	39-02					47,305		47,305	12
13	Other (specify):									13
14	TOTAL			$	3,529	$ 340,920	$ 130,582	3,529	$ 471,502	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 249,687	$	1
2	Cash-Patient Deposits	91,454		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,244,251		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,902		6
7	Other Prepaid Expenses	1,990		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Ex Account	(94,734)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,512,550	$	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	987,346		15
16	Equipment, at Historical Cost	388,725		16
17	Accumulated Depreciation (book methods)	(1,034,836)		17
18	Deferred Charges	278		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): Due to/From Other Funds	717,114		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,058,627	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,571,177	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 770,173	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,371		28
29	Short-Term Notes Payable	1,893,707		29
30	Accrued Salaries Payable	149,459		30
31	Accrued Taxes Payable (excluding real estate taxes)	(21,328)		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	Due to/from Property	1,533,831		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,357,213	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	781,500		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)**	$ 781,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,138,713	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,567,536)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,571,177	$	48

***(See instructions.)**

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,655,073)	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	(3,569)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,658,642)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,091,106	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)**	$ 1,091,106	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)**	$ (2,567,536)	24 *

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

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,777,651	1
2	Discounts and Allowances for all Levels	132,193	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,909,844	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	547,070	6
7	Oxygen	39	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 547,109	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,591	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,943	19
20	Radiology and X-Ray	242	20
21	Other Medical Services	1,330	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,106	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	**Other Income**	9,629	28
28a	**COVID RELATED INCOME**	754,641	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 764,270	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,352,329	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,856,283	31
32	Health Care	3,954,914	32
33	General Administration	1,970,302	33
	B. Capital Expense		
34	Ownership	343,877	34
	C. Ancillary Expense		
35	Special Cost Centers	135,847	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)***	$ 8,261,223	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,091,106	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,091,106	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,835,597	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	969,630	46
47	Other-(specify) **Managed Care**	253,468	47
48	Other-(specify) **Mcr A Anc C/A/Bad Debts/PY**	(148,851)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,909,844	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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	875	1,103	$ 44,122	$ 40.00	1
2	Assistant Director of Nursing	219	219	7,753	35.40	2
3	Registered Nurses	5,286	5,940	186,656	31.42	3
4	Licensed Practical Nurses	31,573	34,824	993,191	28.52	4
5	CNAs & Orderlies	64,841	71,055	1,217,034	17.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,838	5,182	88,193	17.02	9
10	Activity Assistants	2,729	3,142	49,590	15.78	10
11	Social Service Workers	20,332	21,852	370,835	16.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,342	20,590	326,778	15.87	15
16	Dishwashers					16
17	Maintenance Workers	7,109	7,809	129,614	16.60	17
18	Housekeepers	11,915	12,964	206,162	15.90	18
19	Laundry	4,808	5,273	81,621	15.48	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,606	2,848	49,009	17.21	22
23	Office Manager	1,999	2,209	54,354	24.61	23
24	Clerical	4,424	4,498	73,037	16.24	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	573	716	10,746	15.01	31
32	Other Health Care(specify)					32
33	Other(specify) Security	6,143	6,801	113,241	16.65	33
34	TOTAL (lines 1 - 33)	189,612	207,025	$ 4,001,936 *	$ 19.33	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	56	3,640	12-03	45
46	Other(specify)				46
47	Infectious Discease Consultant		1,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	56	$ 5,840		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,157	$ 92,887	10-03	50
51	Licensed Practical Nurses	3,800	178,601	10-03	51
52	Certified Nurse Assistants/Aides	2,146	62,234	10-03	52
53	TOTAL (lines 50 - 52)	8,103	$ 333,722		53

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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	97,790
TOTAL (agree to Schedule V, line 17, col. 3)	$ 633,790
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BKD, LLP	ACCOUNTING	$ 11,750
H2HHS, INC.	MANAGEMENT CONS	47,030
LIFE SAFETY RESOURCES	CONS-BLDG COMP	4,579
MAEMAR	ARCH SERVICES	125
PERSONNEL PLANNER	UNEMPLOYMENT CONS	1,239
MARDELLE GIBBS	MANAGEMENT CONS	6,000
BERGER, NEWMARK & FENCHEI	LEGAL	1,632
TED GIBBS ESQ.	LEGAL	263
	LEGAL (NONALLOWABLE)	44,623
	DATA PROCESSING	80,282
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 197,523

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,604
Unemployment Compensation Insurance	21,719
FICA Taxes	298,334
Employee Health Insurance	199,182
Employee Meals	29,462
Illinois Municipal Retirement Fund (IMRF)*	
401K	32,975
PENSION	
UNIFORMS	
MISC	12,562
TOTAL (agree to Schedule V, line 22, col.8)	$ 703,838

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	158
(Indicate # of checks performed 4)	
Patient Background Checks 99	1,580
Advertising	
Licenses, Dues & Fees	15,436
MADO ALLOCATION	773
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,453
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,453

**See instructions.

Facility Name & ID Number MADO HEALTHCARE UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 UPTOWN # 0023770 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. **NO**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,229** 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. $ **29,462** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

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

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

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

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