

Facility Name & ID Number MADO HEALTHCARE - UPTOWN

0023770 Report Period Beginning: 1/1/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,081			5,081	8
9	SNF/PED					9
10	ICF	39,545			39,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,626			44,626	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.62%

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/1978

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **MADO HEALTHCARE - UPTOWN** # **0023770** Report Period Beginning: **1/1/17** Ending: **12/31/17**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	260,791	35,118	7,263	303,172		303,172		303,172		1
2	Food Purchase		234,948		234,948	(28,194)	206,754		206,754		2
3	Housekeeping	156,526	61,422		217,948		217,948		217,948		3
4	Laundry	147,808	10,066		157,874		157,874		157,874		4
5	Heat and Other Utilities			163,467	163,467		163,467	1,286	164,753		5
6	Maintenance	26,904		230,411	257,315		257,315	(12,135)	245,180		6
7	Other (specify):*	104,838			104,838		104,838		104,838		7
8	TOTAL General Services	696,867	341,554	401,141	1,439,562	(28,194)	1,411,368	(10,849)	1,400,519		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,755,000	123,119	1,200	1,879,319		1,879,319		1,879,319		10
10a	Therapy			272	272		272		272		10a
11	Activities	190,887	13,561	2,200	206,648		206,648		206,648		11
12	Social Services	239,192		5,049	244,241		244,241		244,241		12
13	CNA Training										13
14	Program Transportation			4,312	4,312		4,312		4,312		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,185,079	136,680	13,033	2,334,792		2,334,792		2,334,792		16
	C. General Administration										
17	Administrative	47,919		586,000	633,919		633,919	(424,800)	209,119		17
18	Directors Fees										18
19	Professional Services			62,066	62,066		62,066	(2,030)	60,036		19
20	Dues, Fees, Subscriptions & Promotions			12,794	12,794		12,794	208	13,002		20
21	Clerical & General Office Expenses	40,828	21,058	50,031	111,917		111,917	264,606	376,523		21
22	Employee Benefits & Payroll Taxes			566,087	566,087	28,194	594,281		594,281		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,093	5,093		5,093	(2,951)	2,142		24
25	Other Admin. Staff Transportation							1,246	1,246		25
26	Insurance-Prop.Liab.Malpractice			179,406	179,406		179,406	4,536	183,942		26
27	Other (specify):*							61,034	61,034		27
28	TOTAL General Administration	88,747	21,058	1,461,477	1,571,282	28,194	1,599,476	(98,151)	1,501,325		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,970,693	499,292	1,875,651	5,345,636		5,345,636	(109,000)	5,236,636		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:

1/1/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,208	25,208		25,208	40,448	65,656			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,199	95,199		95,199	31,796	126,995			32
33	Real Estate Taxes							152,206	152,206			33
34	Rent-Facility & Grounds			204,000	204,000		204,000	(204,000)				34
35	Rent-Equipment & Vehicles			5,168	5,168		5,168		5,168			35
36	Other (specify):*											36
37	TOTAL Ownership			329,575	329,575		329,575	20,450	350,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,048		15,048		15,048		15,048			39
40	Barber and Beauty Shops			1,270	1,270		1,270		1,270			40
41	Coffee and Gift Shops		2,799		2,799		2,799	(4,117)	(1,318)			41
42	Provider Participation Fee			345,123	345,123		345,123		345,123			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,847	346,393	364,240		364,240	(4,117)	360,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,970,693	517,139	2,551,619	6,039,451		6,039,451	(92,667)	5,946,784			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(7,039)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29,023)	21		18
19	Entertainment	(2,951)	24		19
20	Contributions	(956)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(206)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,905)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,741)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,821)		\$	30

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	2	
		Amount	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)	(35,846)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,846)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (92,667)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

MADO HEALTHCARE - UPTOWN

ID# 0023770

Report Period Beginning: 1/1/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MISC INCOME	\$ (17,074)	21	1
2	VENDING MACHINE INCOME	(1,318)	41	2
3	BANK CHARGES	(1,286)	21	3
4	MISC-CLIENT CLOTHING	(1,209)	21	4
5	CIGARETTE PURCHASES	(2,799)	41	5
6	ADJ TO S/L DEPR	34,550	30	6
7	CAPITALIZED R&M	(14,605)	6	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				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	(3,741)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MADO HEALTHCARE - UPTOWN

0023770

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,286	0	0	0	0	0	0	0	0	1,286	5
6	Maintenance	(14,605)	0	2,470	0	0	0	0	0	0	0	0	(12,135)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,605)	0	3,756	0	(10,849)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(424,800)	0	0	0	0	0	0	0	0	(424,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,000)	0	8,970	0	0	0	0	0	0	0	0	(2,030)	19
20	Fees, Subscriptions & Promotions	(206)	0	414	0	0	0	0	0	0	0	0	208	20
21	Clerical & General Office Expenses	(51,453)	0	316,059	0	0	0	0	0	0	0	0	264,606	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	(2,951)	0	0	0	0	0	0	0	0	0	0	(2,951)	24
25	Other Admin. Staff Transportation	0	0	1,246	0	0	0	0	0	0	0	0	1,246	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,536	0	0	0	0	0	0	0	0	4,536	26
27	Other (specify):*	0	0	61,034	0	0	0	0	0	0	0	0	61,034	27
28	TOTAL General Administration	(65,610)	0	(32,541)	0	(98,151)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,215)	0	(28,785)	0	(109,000)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MADO HEALTHCARE - UPTOWN# 0023770

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	34,550	0	5,898	0	0	0	0	0	0	0	0	40,448	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,039)	25,412	13,423	0	0	0	0	0	0	0	0	31,796	32
33	Real Estate Taxes	0	146,754	5,452	0	0	0	0	0	0	0	0	152,206	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	27,511	(31,834)	24,773	0	20,450	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	(4,117)	0	0	0	0	0	0	0	0	0	0	(4,117)	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	(4,117)	0	0	0	0	0	0	0	0	0	0	(4,117)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(56,821)	(31,834)	(4,012)	0	(92,667)	45							

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 204,000	4621 PROPERTY LLC	100.00%	\$	(204,000)	1
2	V	32 INTEREST				25,412	25,412	2
3	V	33 REAL ESTATE TAXES				146,754	146,754	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			\$ 172,166	\$ * (31,834)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Mado Management	100.00%	\$ 1,286	\$	1,286	15
16	V	6 Repairs & Maintenance		Mado Management	100.00%	2,470		2,470	16
17	V	19 Professional Fees		Mado Management	100.00%	8,970		8,970	17
18	V	20 Dues and Subscriptions		Mado Management	100.00%	414		414	18
19	V	21 Clerical and General		Mado Management	100.00%	316,059		316,059	19
20	V	25 Auto Expense		Mado Management	100.00%	1,246		1,246	20
21	V	26 Insurance		Mado Management	100.00%	4,536		4,536	21
22	V	27 Employee Benefits		Mado Management	100.00%	38,926		38,926	22
23	V	30 Depreciation		Mado Management	100.00%	5,898		5,898	23
24	V	32 Interest		Mado Management	100.00%	13,423		13,423	24
25	V	33 Real Estate Taxes		Mado Management	100.00%	5,452		5,452	25
26	V								26
27	V	17 Management Fees	486,000	Mado Management	100.00%			(486,000)	27
28	V								28
29	V	17 Salary - P. O'Brien		Mado Management	100.00%	61,200		61,200	29
30	V	27 Employee Benefits		Mado Management	100.00%	6,103		6,103	30
31	V								31
32	V	17 Administrative Salary		Mado Management	100.00%				32
33	V	27 Employee Benefits		Mado Management	100.00%	16,005		16,005	33
34	V								34
35	V	17 Administrative Salary	100,000	Mado Management	100.00%	100,000			35
36	V								36
37	V								37
38	V								38
39	Total		\$ 586,000			\$ 581,988	\$ *	(4,012)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 Dietary	\$ 7,263	MADO LLC	100.00%	\$ 7,263	\$	15
16	V	6 CONTRACT LABOR	96,025	MADO LLC		96,025		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		\$ 103,288			\$ 103,288	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	\$ *

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

Facility Name & ID Number MADO HEALTHCARE - UPTOWN # 0023770 Report Period Beginning: 1/1/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	PETER O'BRIEN	OWNER	ADMINISTRATIV	100.00	SEE ATTACHED	11.7	19.55	ALLOC SAL	\$ 61,200	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	\$ 61,200		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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	174,994	4	\$ 5,041	\$ 44,626	\$ 1,286	1
2	6	Repair & Maintenance	Patient Days	174,994	4	9,685	44,626	2,470	2
3	19	Professional Fees	Patient Days	174,994	4	35,176	44,626	8,970	3
4	20	Dues and Subscriptions	Patient Days	174,994	4	1,623	44,626	414	4
5	21	Clerical and General	Patient Days	174,994	4	1,239,374	1,202,338	316,059	5
6	25	Auto Expense	Patient Days	174,994	4	4,886	44,626	1,246	6
7	26	Insurance	Patient Days	174,994	4	17,788	44,626	4,536	7
8	27	Employee Benefits	Patient Days	174,994	4	152,643	44,626	38,926	8
9	30	Depreciation	Patient Days	174,994	4	23,129	44,626	5,898	9
10	32	Interest	Patient Days	174,994	4	52,635	44,626	13,423	10
11	33	Real Estate Taxes	Patient Days	174,994	4	21,380	44,626	5,452	11
12									12
13	17	Salary - P. O'Brien	Avg Hrs Worked		4	240,000	240,000	61,200	13
14	27	Employee Benefits	Avg Hrs Worked		4	23,933		6,103	14
15									15
16	17	Administrative Salary	Direct Allocation			10,850	10,850	0	16
17	27	Employee Benefits	Direct Allocation			52,472		16,005	17
18									18
19	17	Administrative Salary	Direct Allocation			356,119	356,119	100,000	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,246,734	\$ 1,809,307	\$ 581,988	25

Facility Name & ID Number MADO HEALTHCARE - UPTOWN

0023770

Report Period Beginning:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

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Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: **12/31/17**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

1/1/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	BRIDGEVIEW BANK		X					\$	28,276		\$	25,412	1							
2	(4621 CORP)												2							
3													3							
4													4							
5													5							
Working Capital																				
6	BRIDGEVIEW BANK		X						1,543,750			42,353	6							
7	SIGNATURE BANK		X						1,056,678			45,807	7							
8													8							
9	TOTAL Facility Related							\$	2,628,704		\$	113,572	9							
B. Non-Facility Related*																				
10	R/E TAX INTEREST											7,039	10							
11													11							
12													12							
13	ALLOC FROM MADO MGT											13,423	13							
14	TOTAL Non-Facility Related							\$			\$	20,462	14							
15	TOTALS (line 9+line14)							\$	2,628,704		\$	134,034	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.		\$	161,659	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.)		\$	145,218	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(16,441)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	168,647	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.		\$	152,206	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	111,208	8	
	2013	123,626	9	
	2014	125,972	10	
	2015	127,931	11	
	2016	139,766	12	
Allocated from MADO Management - \$5,452				

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

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
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.

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: FACILITY, 12,868, 1984, \$ 70,700, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 12,868, (blank), \$ 70,700, 3.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1984	1975	\$ 1,494,824	\$	35	\$	\$	\$ 1,494,824	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			682	682	12,843	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			1,438	1,438	69,848	26
27	Various		1998		56,951			2,848	2,848	55,582	27
28	Various		1999		93,038			4,652	4,652	86,329	28
29	Various		2000		84,672			4,234	4,234	73,978	29
30	Various		2001		72,394			3,620	3,620	60,092	30
31	Various		2002		121,688					121,688	31
32	Various		2003		57,379			2,869	2,869	41,592	32
33	Various		2004		89,609					89,609	33
34	Various		2005		31,058			2,009	2,009	31,058	34
35	Various		2006		23,468			1,497	1,497	23,468	35
36	Various		2007		10,166			508	508	5,263	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:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2008	\$ 18,781	\$	20	\$ 939	\$ 939	\$ 9,035	37
38	Replace Fire Doors	2009	3,772		20	189	189	1,589	38
39	Electrical Work In The Courtyard	2009	7,185		20	359	359	3,082	39
40	Electric Lock For Pedestrian Gate	2009	2,584		20	129	129	1,108	40
41	Brick Patio & Retaining Wall	2009	4,100		20	205	205	1,760	41
42	Repairs To Air Conditioning System	2009	2,685		20	134	134	1,118	42
43	Condensing Motor Fan	2009	4,433		20	222	222	1,886	43
44	Fire Alarm Wiring	2009	3,453		20	173	173	1,527	44
45	Therapy - Whirlpool Tub	2010	8,437		20	422	422	3,059	45
46	Furnish & Install Water Heater	2010	9,735		20	487	487	3,895	46
47	Sprinkler Heads	2010	4,769		20	238	238	1,826	47
48	Electrical Work - Elevator	2010	16,786		20	839	839	6,363	48
49	Electrical Work	2010	9,935		20	497	497	3,685	49
50	Cold Water Pressure Pump	2011	3,785		20	189	189	1,197	50
51	Fire Escape Improvement Per Idph Requirement	2011	17,595		20	880	880	6,086	51
52	Replaced Burned Wire, Filters For Two Compressors	2011	3,665		20	183	183	1,205	52
53	20 Ton Semi-Hermetic Reciprocating Compressor	2012	13,730		20	687	687	3,664	53
54	Bathroom Renovation (Ceiling, Electrical, Plumbing, Drywall, Flo	2012	8,570		20	429	429	2,181	54
55	Install New Dampers	2012	3,370		20	169	169	859	55
56	Sealed Wall Cracks; Rebuilt Damage Part Wall	2012	3,850		20	193	193	1,158	56
57	Installed New Valve And Drained Line	2012	4,654		20	233	233	1,398	57
58	Fire Sprinkler Repairs	2012	5,859		20	293	293	1,758	58
59	Fire Alarm Repairs	2012	3,762		20	188	188	1,128	59
60	Furnished And Installed Heating Elements For Water Heater Boo	2012	2,663		20	133	133	798	60
61	Replaced Armaflex Insulation	2012	3,546		20	177	177	1,062	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	\$		\$ 32,944	\$ 32,944	\$ 2,755,806	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:

1/1/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,917,641	\$		\$ 32,944	\$ 32,944	\$ 2,755,806	1
2									2
3	Bathrooms-2nd-4th floor north - drywall, floors, fixtures, painting	2013	31,539		20	1,577	1,577	6,342	3
4	Asphalt Resurface	2013	12,500		8	1,563	1,563	6,643	4
5	Repaired South Passenger Elevator	2013	4,021		20	201	201	938	5
6	Repaired Mop Sink	2013	2,500		20	125	125	510	6
7	Install New 50 HP 230 Volt Pump Motor	2013	3,039		15	203	203	829	7
8	Excavated 25 Feet for Washing machine Line	2013	4,300		25	172	172	745	8
9	Repaired Fire Alarm System	2013	2,509		10	251	251	1,255	9
10	Tamper Panel Fire Detection System	2014	15,800		10	1,580	1,580	6,320	10
11	Steam Boiler	2014	34,860		20	1,743	1,743	6,536	11
12	Steam Compressor	2014	19,670		20	984	984	3,526	12
13	Bathrooms-2nd-5th floor south - materials and labor to replace	2014	65,876		20	3,294	3,294	10,157	13
14	walls, ceilings, floors, electrical & plumbing, fixtures; painting								14
15	Elevator repair-Hydraulic valve	2014	2,991		20	150	150	463	15
16	Elevator repair-Upgrades	2015	15,740		20	787	787	2,361	16
17	Elevator repair-Upgrades	2015	47,600		20	2,380	2,380	6,743	17
18	1st floor bathroom materials-electrical, floors, fixtures, drywall, pa	2015	2,713		20	136	136	283	18
19	Warehouse, laundry, 1st flr bthrm materials-electrical, floors, fixt	2015	3,398		20	170	170	340	19
20	Repaired hydraulic pistons - south elevator	2015	3,095		20	155	155	362	20
21	#1 & 2 Elevators-Wiring. Furnish & install 2 emergency telephone	2015	2,561		20	128	128	277	21
22	Kitchen Ventilation Fan	2016	3,000		20	150	150	275	22
23	Elevator-Replace car sill, new gibbs and hangers	2016	2,969		20	148	148	284	23
24	Elevator-Replace Hydraulic valve & oil	2016	4,419		20	221	221	405	24
25	Elevator-Repairs to North & South	2016	7,320		20	366	366	397	25
26	Elevator Repairs-#1 & #2	2017	2,793		20	93	93	93	26
27	Elevator Repairs-#2	2017	8,350		20				27
28	Replaced 3 steam traps	2017	3,462		20	115	115	115	28
29									29
30									30
31	F/S Depreciation			23,308			(23,308)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,224,666	\$ 23,308		\$ 49,636	\$ 26,328	\$ 2,812,004	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,224,666	\$ 23,308		\$ 49,636	\$ 26,328	\$ 2,812,004	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	1988	52,858	1,975	35	1,510	(465)	33,225	4
5	Direct Allocation from Mado	1985	21,630		35	618	618	13,596	5
6	Direct Allocation from Mado	2009	6,540		35	187	187	1,505	6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management	1995	1,226		20			1,226	9
10	Allocated from Mado Management	1993	20,134		20			20,134	10
11	Allocated from Mado Management	2000	3,011		20	151	151	2,638	11
12	Allocated from Mado Management	2001	1,304		20	65	65	1,026	12
13	Allocated from Mado Management	2002	2,052		20			2,052	13
14	Allocated from Mado Management	2004	577	7	20	29	22	384	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)		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	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		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	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
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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		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	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		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	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)	\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	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)	\$ 3,333,998	\$ 25,290		\$ 52,196	\$ 26,906	\$ 2,887,789	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 125,142	\$ 1,900	\$ 6,100	\$ 4,200	Various	\$ 105,644	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	251,747						73
74								74
75	TOTALS	\$ 376,889	\$ 1,900	\$ 6,100	\$ 4,200		\$ 105,644	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	2010	\$ 46,368	\$ 3,916	\$ 7,360	\$ 3,444	5	\$ 27,782	76
77										77
78										78
79										79
80	TOTALS			\$ 46,368	\$ 3,916	\$ 7,360	\$ 3,444		\$ 27,782	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,827,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,106	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,656	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,550	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,021,215	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: 1/1/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 5,168 Description: Ice Machine \$1,177; Copiers \$3,991

(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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39-02	# of prescripts				15,048		15,048	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$ 15,048		\$ 15,048	14	

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,989	\$	1
2	Cash-Patient Deposits	7,275		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	555,472		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,467		6
7	Other Prepaid Expenses	1,990		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Ex Acct	(22,457)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 566,736	\$	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	1,022,005		15
16	Equipment, at Historical Cost	348,666		16
17	Accumulated Depreciation (book methods)	(975,956)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due T/F Others	2,138,598		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,533,313	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,100,049	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 664,208	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	335		28
29	Short-Term Notes Payable	2,600,428		29
30	Accrued Salaries Payable	65,797		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Due To/From Prop	1,633,978		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,964,746	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,964,746	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,864,697)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,100,049	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,339,369)	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	(1,676)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,341,045)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(523,652)	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)	\$ (523,652)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,864,697)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MADO HEALTHCARE - UPTOWN

0023770

Report Period Beginning: 1/1/17

Ending:

12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,528,531	1
2	Discounts and Allowances for all Levels	(31,124)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,497,407	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,318	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,318	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	17,074	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,074	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,515,799	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,439,562	31
32	Health Care	2,334,792	32
33	General Administration	1,571,282	33
B. Capital Expense			
34	Ownership	329,575	34
C. Ancillary Expense			
35	Special Cost Centers	19,117	35
36	Provider Participation Fee	345,123	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,039,451	40
41	Income before Income Taxes (line 30 minus line 40)**	(523,652)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (523,652)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 5,528,531	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify) PRIOR YR ADJ/BAD DEBTS	(31,124)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,497,407	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:

1/1/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,827	2,091	\$ 73,499	\$ 35.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,947	7,789	227,062	29.15	3
4	Licensed Practical Nurses	27,917	30,173	750,377	24.87	4
5	CNAs & Orderlies	53,110	57,924	704,062	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,821	1,990	26,082	13.11	9
10	Activity Assistants	14,008	15,129	164,805	10.89	10
11	Social Service Workers	16,337	17,922	239,192	13.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,844	22,717	260,791	11.48	15
16	Dishwashers					16
17	Maintenance Workers	2,196	2,373	26,904	11.34	17
18	Housekeepers	13,408	14,262	156,526	10.98	18
19	Laundry	12,889	13,673	147,808	10.81	19
20	Administrator					20
21	Assistant Administrator	1,849	2,074	47,919	23.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,699	2,947	40,828	13.85	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	8,148	8,995	104,838	11.66	33
34	TOTAL (lines 1 - 33)	185,000	200,059	\$ 2,970,693 *	\$ 14.85	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	MONTHLY 250	10-03	38
39	Pharmacist Consultant	MONTHLY 950	10-03	39
40	Physical Therapy Consultant		10a-03	40
41	Occupational Therapy Consultant	4	10a-03	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	44	11-03	44
45	Social Service Consultant	74	12-03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	122	\$ 8,721	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,889 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. \$ 345,123
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 28,194 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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 of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees