

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0056861

Facility Name: Fargo Health Care Center

Address: 1512 West Fargo Ave Chicago 60626
Number City Zip Code

County: Cook

Telephone Number: (773)465-7751 Fax # (773)465-2104

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2021

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Judd Schneider Telephone Number: (847)933-1274
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 01/01/2025 to 12/31/2025 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) See Accountant's Report Attached
(Firm Name & Address) Mendel Schneider CPA & Associates
4051 Old Orchard Rd, Skokie, IL 60076
(Telephone) (847)933-1274 Fax # (847)933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Fargo Health Care Center # 0056861 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,585	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	3,383	26,508	3,755		392	213		34,251	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,383	26,508	3,755		392	213		34,251	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.79%

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 01/01/2021

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 01/01/2021 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 70

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Fargo Health Care Center** # **0056861** Report Period Beginning: **01/01/2025** Ending: **12/31/2025**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	381,694	30,866	9,209	421,769		421,769		421,769			1
2	Food Purchase		280,604		280,604		280,604		280,604			2
3	Housekeeping	232,111	68,564	13,573	314,248		314,248		314,248			3
4	Laundry	149,814	19,689		169,503		169,503		169,503			4
5	Heat and Other Utilities			157,235	157,235		157,235	2,822	160,057			5
6	Maintenance	87,028	33,771	93,931	214,730		214,730	147	214,877			6
7	Other (specify):*											7
8	TOTAL General Services	850,647	433,494	273,948	1,558,089		1,558,089	2,969	1,561,058			8
	B. Health Care and Programs											
9	Medical Director			23,200	23,200		23,200		23,200			9
10	Nursing and Medical Records	2,605,183	89,453	32,771	2,727,407		2,727,407		2,727,407			10
10a	Therapy											10a
11	Activities	112,598	2,049	4,121	118,768		118,768		118,768			11
12	Social Services	126,527		6,131	132,658		132,658		132,658			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,844,308	91,502	66,223	3,002,033		3,002,033		3,002,033			16
	C. General Administration											
17	Administrative	131,459		540,000	671,459		671,459	(497,910)	173,549			17
18	Directors Fees											18
19	Professional Services			179,389	179,389		179,389	(66,707)	112,682			19
20	Dues, Fees, Subscriptions & Promotions			52,012	52,012		52,012	(15,984)	36,028			20
21	Clerical & General Office Expenses	290,535	96,569	268,449	655,553		655,553	311,757	967,310			21
22	Employee Benefits & Payroll Taxes			589,481	589,481		589,481	33,381	622,862			22
23	Inservice Training & Education											23
24	Travel and Seminar			551	551		551	376	927			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			350,990	350,990		350,990		350,990			26
27	Other (specify):*							53,375	53,375			27
28	TOTAL General Administration	421,994	96,569	1,980,872	2,499,435		2,499,435	(181,712)	2,317,723			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,116,949	621,565	2,321,043	7,059,557		7,059,557	(178,743)	6,880,814			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			61,982	61,982		61,982	288,469	350,451			30
31	Amortization of Pre-Op. & Org.							12,143	12,143			31
32	Interest			27,084	27,084		27,084	426,279	453,363			32
33	Real Estate Taxes							284,447	284,447			33
34	Rent-Facility & Grounds			864,000	864,000		864,000	(858,620)	5,380			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP							20,592	20,592			36
37	TOTAL Ownership			953,066	953,066		953,066	173,310	1,126,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,533	66,205	78,738		78,738		78,738			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			741,059	741,059		741,059		741,059			42
43	Other (specify):* Bad Debt			8,368	8,368		8,368	(8,368)				43
44	TOTAL Special Cost Centers		12,533	815,632	828,165		828,165	(8,368)	819,797			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,116,949	634,098	4,089,741	8,840,788		8,840,788	(13,801)	8,826,987			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(206,318)	30		9
10	Interest and Other Investment Income	(10,658)	32		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	(3,960)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,368)	43		24
25	Fund Raising, Advertising and Promotional	(6,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (235,586)		\$	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)	227,527		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 227,527		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (8,059)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (5,742)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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47				47
48				48
49	Total	(5,742)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 864,000	1512 W Fargo LLC		\$	(864,000)	1
2	V	30	Depreciation		1512 W Fargo LLC		494,787	494,787	2
3	V	31	Amortization		1512 W Fargo LLC		12,143	12,143	3
4	V	32	Interest		1512 W Fargo LLC		436,937	436,937	4
5	V	33	Real Estate Tax		1512 W Fargo LLC		284,447	284,447	5
6	V	21	Office		1512 W Fargo LLC		2,653	2,653	6
7	V	19	Prof Fees		1512 W Fargo LLC		14,860	14,860	7
8	V	36	Mip Expense		1512 W Fargo LLC		20,592	20,592	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 864,000			\$ 1,266,419	\$ * 402,419	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	17	Management Fees	\$ 540,000	AE Financial Services		\$	(540,000)	15
16	V	21	Office Payroll		AE Financial Services		295,428	295,428	16
17	V	21	Office		AE Financial Services		39,777	39,777	17
18	V	27	Health Insurance		AE Financial Services		53,375	53,375	18
19	V	17	Administrative Salaries		AE Financial Services		42,090	42,090	19
20	V	6	Repairs & Maintenance		AE Financial Services		147	147	20
21	V	22	Payroll Taxes		AE Financial Services		33,381	33,381	21
22	V	34	Rent		AE Financial Services		5,380	5,380	22
23	V	19	Professional Fees	81,944	AE Financial Services		377	(81,567)	23
24	V	21	Office	26,101	AE Financial Services			(26,101)	24
25	V	5	Utilities		AE Financial Services		2,822	2,822	25
26	V	24	Seminar		AE Financial Services		376	376	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			\$ 648,045			\$ 473,153	\$ * (174,892)	39

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

Ownership Listing-2

ID# 0056861

12/31/2025

-Owners of companies must be listed instead of company names.

Place of Residence

Ownership

Ownership

Ownership

Ownership

76								76
77								77
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150								150

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Atrium Rehab & Nursing Center	Chicago,Il			AE Financial Service	Lincolnwood,IL	Mgmt	1
2	Irving Park Nursing & Rehab	Chicago,Il			1512 W Fargo	Chicago,IL	BLDG rental	2
3	North Aurora Living & Rehab Center	North Aurora,IL						3
4	Sandwich Living & Rehab Center	Sandwich,Il						4
5	South Elgin Living & Rehab Center	South Elgin,Il						5
6								6
7								7
8								8
9								9
10								10
11								11
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29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aharon Diena	Owner	Administrative	44.95	115,855	7	17.00	Allocated Wag	\$ 21,045	17-7	1
2	Ephraim Braunstein	Owner	Administrative	44.95	115,855	7	17.00	Allocated Wages	21,045	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,090		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 Fargo Health Care Center # 0056861 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization AE Financial Services
Street Address 3737 W Arthur Ave
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847)679-2121
Fax Number (847)679-2122

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	21	Office Payroll	Number of Beds	644	6	\$ 1,921,773	\$	99	\$ 295,428	1
2	21	Office	Number of Beds	644	6	258,753		99	39,777	2
3	27	Health Insurance	Number of Beds	644	6	347,207		99	53,375	3
4	17	Administrative Salaries	Number of Beds	644	6	273,800	273,800	99	42,090	4
5	6	Repairs & Maintenance	Number of Beds	644	6	955		99	147	5
6	22	Payroll Taxes	Number of Beds	644	6	217,145		99	33,381	6
7	19	Professional Fees	Number of Beds	644	6	2,450		99	377	7
8	34	Rent	Number of Beds	644	6	35,000		99	5,380	8
9	5	Utilities	Number of Beds	644	6	18,356		99	2,822	9
10	24	Seminar	Number of Beds	644	6	2,449		99	376	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					\$ 3,077,888	\$ 273,800		\$ 473,153	25

Facility Name & ID Number Fargo Health Care Center # 0056861 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

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	Greystone		X	Mortgage			\$	8,236,700			\$	436,937	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Midland Bank		X	Working Capital				150,000				27,084	6
7													7
8													8
9	TOTAL Facility Related						\$	8,386,700			\$	464,021	9
	B. Non-Facility Related*												
10	Interest Income											(10,658)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(10,658)	14
15	TOTALS (line 9+line14)						\$	8,386,700			\$	453,363	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,592 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	221,319	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.)				\$	246,715	2
3. Under or (over) accrual (line 2 minus line 1).				\$	25,396	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	259,051	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.				\$	284,447	7
Assessed Value from Real Estate Tax Bill:	2024	1,228,000	8			
Real Estate Tax Bill for Calendar Year:	2020		9			
	2021	200,890	10			
	2022	205,477	11			
	2023	210,780	12			
	2024	246,715	13			
246715 x 1.05						
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fargo Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056861

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	11-29-306-024-0000	LTC Property	\$ 246,714.74	\$ 246,714.74
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 246,714.74	\$ 246,714.74

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: 354,476 2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 12,143 4. Dates Incurred: 12/18/2025

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2020	\$ 717,750	1
2					2
3	TOTALS			\$ 717,750	3

Facility Name & ID Number Fargo Health Care Center

0056861

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		2021		\$ 4,800,673	\$	27.5	\$ 174,570	\$ 174,570	\$ 872,850
5										
6										
7										
8										
	Improvement Type**									
9	Major Roof Improvement			2021	3,500		20	175	175	875
10	Remove and Replace Existing Outside Ramps & Remove			2022	29,100		15	1,940	1,940	7,760
11	and Replace Front Walls									
12	Alarm			2023	5,337		15	356	356	1,424
13	3 Inroom Unit A/C			2024	4,179		15	279	279	697
14	Tie Tamper Circuit, Supervisory Bell,Annunciator to Existing Fire			2024	4,500		15	300	300	750
15	Alarm System									
16	Valve Replacement in Elevator 1			2025	9,260		15	617	617	617
17	Repave visitor parking lot			2025	20,663		15	1,378	1,378	1,378
18	New main entrance entry door			2025	17,026		15	1,135	1,135	1,135
19										
20										
21	Financial Statement Depreciation					556,769			(556,769)	
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,894,238	\$ 556,769		\$ 180,749	\$ (376,020)	\$ 887,486	70

**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	\$ 1,683,294	\$	\$ 168,329	\$ 168,329	10	\$ 838,298	71
72	Current Year Purchases	13,730		1,373	1,373	10	1,373	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,697,024	\$	\$ 169,702	\$ 169,702		\$ 839,671	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 7,309,012	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 556,769	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 350,451	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (206,318)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,727,157	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated Rent				5,380			5
6								6
7	TOTAL				\$ 5,380			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.
9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 28,963	\$		\$ 28,963	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,947			3,947	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			33,295			33,295	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				8,569		8,569	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10										10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					3,964		3,964	12
13	Other (specify):									13
14	TOTAL			\$		\$ 66,205	\$ 12,533		\$ 78,738	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.

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	\$ (27,507)	\$ 62,040	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,533,487	1,533,487	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,991	1,991	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows, due from others		1,683,312	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,507,971	\$ 3,280,830	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		717,750	13
14	Buildings, at Historical Cost		4,800,673	14
15	Leasehold Improvements, at Historical Cost	93,565	93,565	15
16	Equipment, at Historical Cost	37,947	1,697,024	16
17	Accumulated Depreciation (book methods)	(125,546)	(3,047,650)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		395,576	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(146,106)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,966	\$ 4,510,832	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,513,937	\$ 7,791,662	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 170,809	\$ 170,809	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	122,383	122,383	28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	208,981	208,981	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		259,051	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to others	18,166	18,166	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 670,339	\$ 929,390	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,236,700	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)	\$	\$ 8,236,700	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 670,339	\$ 9,166,090	46
47	TOTAL EQUITY(page 18, line 24)	\$ 843,598	\$ (1,374,428)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,513,937	\$ 7,791,662	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (383,219)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (383,219)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,424,817	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	(198,000)	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)	\$ 1,226,817	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)	\$ 843,598	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fargo Health Care Center

0056861

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,759,043	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,759,043	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	1,495,904	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,495,904	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,658	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,658	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,265,605	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,558,089	31
32	Health Care	3,002,033	32
33	General Administration	2,499,435	33
	B. Capital Expense		
34	Ownership	953,066	34
	C. Ancillary Expense		
35	Special Cost Centers	87,106	35
36	Provider Participation Fee	741,059	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,840,788	40
41	Income before Income Taxes (line 30 minus line 40)**	1,424,817	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,424,817	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 843,057.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,605,897.00	45
46	MMAI-Medicaid is the Primary Payer	935,761.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	132,298.00	48
49	Medicare Part A	213,759.00	49
50	Other-(specify) Med B Income	28,271.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,759,043	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,012	2,180	\$ 124,750	\$ 57.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,713	9,785	517,455	52.88	3
4	Licensed Practical Nurses	18,028	19,496	938,001	48.11	4
5	CNAs & Orderlies	42,004	44,539	1,024,977	23.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,743	5,234	112,598	21.51	10
11	Social Service Workers	4,227	4,307	126,527	29.38	11
12	Dietician					12
13	Food Service Supervisor	2,088	2,216	72,463	32.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,427	15,353	309,231	20.14	15
16	Dishwashers					16
17	Maintenance Workers	3,919	4,271	87,028	20.38	17
18	Housekeepers	9,554	10,463	232,111	22.18	18
19	Laundry	5,665	6,301	149,814	23.78	19
20	Administrator	2,000	2,056	131,459	63.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,657	10,346	290,535	28.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,037	136,547	\$ 4,116,949 *	\$ 30.15	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,208	1-3	35
36	Medical Director	Monthly	23,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,007	10-3	39
40	Physical Therapy Consultant	Monthly	15,053	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	6,614	10-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 61,082		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

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

** See instructions.

Facility Name & ID Number	Fargo Health Care Center
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0056861

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

Amount

HEALTH CARE COUNCIL OF IL (HCCI)

11,484

11,484 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)

5,742

5,742 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)

17,226

17,226 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$

14,918

Line

10
- (6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$

741,059

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee?

No

If YES, attach an explanation of the allocation.

- (9)

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

Yes
- (10)

Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B?

No

For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$

None

Has any meal income been offset against
related costs?

None

Indicate the amount.

\$
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for
residents?

No

If YES, please indicate the amount of income earned from such a
program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

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?

No

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.

\$
- (13)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:
- (14)

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

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.