FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0053223

Facility Name: Bella Terra Morton Grove

Address: 8425 Waukegan Road (Number) Morton Grove (City) 60053 (Zip Code)

County: Cook

Telephone Number: (847) 965-8100 **Fax #** (847) 965-8104

HFS ID Number:

Date of Initial License for Current Owners: 2014

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/20 to 12/31/20 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) 05/09/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	211	Skilled (SNF)	211	77,226	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	732	5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,401	6,262	6,916	49,579	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,401	6,262	6,916	49,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.60%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 2014

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 2014 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 211 and days of care provided 5,810

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		826	1,297,735	1,298,561		1,298,561	4,020	1,302,581			1
2	Food Purchase		4,178		4,178		4,178	3,559	7,737			2
3	Housekeeping	87	(871)	588,016	587,232		587,232	2,607	589,839			3
4	Laundry	74,394	29,071	119,174	222,639		222,639	177	222,816			4
5	Heat and Other Utilities			241,194	241,194		241,194	(12,275)	228,919			5
6	Maintenance	148,992	18,773	178,610	346,375		346,375	7,742	354,117			6
7	Other (specify):*											7
8	**TOTAL General Services**	223,473	51,977	2,424,729	2,700,179		2,700,179	5,829	2,706,008			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,454,102	391,064	48,706	4,893,872		4,893,872	128,324	5,022,196			10
10a	Therapy	100,562			100,562		100,562		100,562			10a
11	Activities	213,144	9,717	3,189	226,050		226,050	10	226,060			11
12	Social Services	301,968	418	5,051	307,437		307,437	6,984	314,421			12
13	CNA Training											13
14	Program Transportation			26,048	26,048		26,048		26,048			14
15	Other (specify):*							7,244	7,244			15
16	**TOTAL Health Care and Programs**	5,069,776	401,199	94,994	5,565,969		5,565,969	142,562	5,708,531			16
	C. General Administration											
17	Administrative	188,068			188,068		188,068	77,741	265,809			17
18	Directors Fees											18
19	Professional Services			431,409	431,409	(29,228)	402,181	(215,172)	187,009			19
20	Dues, Fees, Subscriptions & Promotions			166,602	166,602		166,602	(120,962)	45,640			20
21	Clerical & General Office Expenses	150,090	2,783	376,521	529,394		529,394	86,629	616,023			21
22	Employee Benefits & Payroll Taxes			793,112	793,112		793,112		793,112			22
23	Inservice Training & Education											23
24	Travel and Seminar			193	193		193	174	367			24
25	Other Admin. Staff Transportation			762	762		762	5,812	6,574			25
26	Insurance-Prop.Liab.Malpractice			384,679	384,679		384,679	28,777	413,456			26
27	Other (specify):*							31,159	31,159			27
28	**TOTAL General Administration**	338,158	2,783	2,153,278	2,494,219	(29,228)	2,464,991	(105,842)	2,359,148			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,631,407	455,959	4,673,001	10,760,367	(29,228)	10,731,139	42,549	10,773,688			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 Bella Terra Morton Grove #0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							424,826	424,826			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,658	13,658		13,658	843,992	857,650			32
33	Real Estate Taxes			308,013	308,013	29,228	337,241	568,871	906,112			33
34	Rent-Facility & Grounds			1,806,237	1,806,237		1,806,237	(1,806,116)	121			34
35	Rent-Equipment & Vehicles			5,730	5,730		5,730	5,646	11,376			35
36	Other (specify):*							131,865	131,865			36
37	**TOTAL Ownership**			2,133,638	2,133,638	29,228	2,162,866	169,083	2,331,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	14,799	363,135	1,119,920	1,497,854		1,497,854	(10,761)	1,487,093			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			398,342	398,342		398,342		398,342			42
43	Other (specify):*			692,557	692,557		692,557	(692,557)	0			43
44	**TOTAL Special Cost Centers**	14,799	363,135	2,210,819	2,588,753		2,588,753	(703,318)	1,885,435			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,646,206	819,094	9,017,458	15,482,758		15,482,758	(491,686)	14,991,072			45

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,635)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	60,688	30		9
10	Interest and Other Investment Income	(8,441)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,086)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5)	02		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	(1,830)	21		18
19	Entertainment	(1,677)	21		19
20	Contributions	(98,187)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(221,734)	21		24
25	Fund Raising, Advertising and Promotional	(6,964)	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	(889,873)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,185,744)		$	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)	694,058		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 694,058		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (491,686)		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

Bella Terra Morton Grove

ID# 0053223

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Expense	$ (691,226)	43	1
2	Patient Personal Items	(2,879)	10	2
3	Bank Charges	(50)	21	3
4	Sequestration Expense	(24,941)	21	4
5	Building Company - Filing Fees	(375)	20	5
6	Building Company - Misc Fees Expense	(90)	21	6
7	Building Company - Accounting Fees	(36,550)	19	7
8	Building Company - Amortization	(80,599)	36	8
9	Capitalized R&M	(6,204)	06	9
10	Non-Alloawble Expense	(1,331)	43	10
11	Out of Period Dues	(519)	20	11
12	PAC Dues	(19,650)	20	12
13	Non-Allowable Legal	(25,459)	19	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**	(889,873)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Bella Terra Morton Grove

IDH **0053223**

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			4,020									4,020	1
2	Food Purchase	(4,091)		7,649									3,559	2
3	Housekeeping			2,607									2,607	3
4	Laundry			177									177	4
5	Heat and Other Utilities	(13,635)				1,360							(12,275)	5
6	Maintenance	(6,204)		13,069		1,318			(441)				7,742	6
7	Other (specify):*													7
8	**TOTAL General Services**	(23,930)		27,523		2,677			(441)				5,829	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,879)		133,690			(2,487)						128,324	10
10a	Therapy													10a
11	Activities			10									10	11
12	Social Services			6,984									6,984	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				7,244								7,244	15
16	**TOTAL Health Care and Programs**	(2,879)		140,685	7,244		(2,487)						142,562	16
	C. General Administration													
17	Administrative			77,741									77,741	17
18	Directors Fees													18
19	Professional Services	(62,009)	36,550	(184,478)		572		(5,806)					(215,172)	19
20	Fees, Subscriptions & Promotions	(125,695)	375	4,358		1							(120,962)	20
21	Clerical & General Office Expenses	(250,322)	90	336,544		316							86,629	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			174									174	24
25	Other Admin. Staff Transportation			5,812									5,812	25
26	Insurance-Prop.Liab.Malpractice		28,282	153		341							28,777	26
27	Other (specify):*			31,159									31,159	27
28	**TOTAL General Administration**	(438,027)	65,297	271,463		1,230		(5,806)					(105,842)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(464,835)	65,297	439,671	7,244	3,907	(2,487)	(5,806)	(441)				42,549	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	60,688	355,751			8,387							424,826	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,441)	847,720			4,713							843,992	32
33	Real Estate Taxes		564,589			4,282							568,871	33
34	Rent-Facility & Grounds		(1,806,237)	39,464		(39,343)							(1,806,116)	34
35	Rent-Equipment & Vehicles				5,646								5,646	35
36	Other (specify):*	(80,599)	212,464										131,865	36
37	TOTAL Ownership	(28,352)	174,287	39,464	5,646	(21,962)							169,083	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(10,761)		(10,761)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(692,557)											(692,557)	43
44	TOTAL Special Cost Centers	(692,557)									(10,761)		(703,318)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,185,744)	239,584	479,135	12,889	(18,054)	(2,487)	(5,806)	(441)		(10,761)		(491,686)	45

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,806,237	MG Property Holdings		$	$ (1,806,237)	1
2	V	32	Interest	1,539	MG Property Holdings		849,259	847,720	2
3	V	33	Real Estate Taxes		MG Property Holdings		564,589	564,589	3
4	V	26	Property Insurance		MG Property Holdings		28,282	28,282	4
5	V	36	MIP		MG Property Holdings		131,865	131,865	5
6	V	20	Filing Fees		MG Property Holdings		375	375	6
7	V	21	Misc. Fees Expense		MG Property Holdings		90	90	7
8	V	19	Accounting Fees		MG Property Holdings		36,550	36,550	8
9	V	30	Depreciation		MG Property Holdings		355,751	355,751	9
10	V	36	Amortization		MG Property Holdings		80,599	80,599	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,807,776			$ 2,047,360	$ * 239,584	14

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GPN Family Trust	6.50%	Astoria Place Skilled Nursing Facility LLC	Chicago	MG Property Holdings		Building Company	1
2	Menchem & Ahuva Shabat	6.50%	Avantara Arlington	Arlington, SD	Legacy HC & Financial Services	Lincolnwood	Home Office/Bookkeeping	2
3	Jack Rajchenbach 2015 Family Trust	3.00%	Avantara Armour	Armour, SD	CF St. Louis LLC	Skokie	Building Company	3
4	Ronald Shabat	3.00%	Avantara Arrowhead	Rapid City, SD	ML Group Design & Development	Skokie	Asset Management	4
5	Chaim Rajchenbach	40.50%	Avantara Aurora	Aurora	ReMED Services LLC	Lincolnwood	Nursing Equipment	5
6	Menachem Shabat	40.50%	Avantara Billings	Billings, MT	Propay HR	Evanston	Payroll Processing	6
7			Avantara Clark	Clark, SD	Ecobrite Linen	Skokie	Laundry Supplies	7
8			Avantara Elgin	Elgin	Aurora Supportive Living	Aurora	Supportive Living	8
9			Avantara Evergreen Park	Evergreen Park	Terrace Gardens	Morton Grove	Assisted Living	9
10			Avantara Groton	Groton, SD	Lincolnshire Assisted Living Center	Lincolnshire	Assisted Living	10
11			Avantara Huron	Huron, SD	Wellshire Park Place	Milbank, SD	Assisted Living	11
12			Avantara Ipswich	Ipswich, SD	Wellshire Huron	Huron, SD	Assisted Living	12
13			Avantara Lake Norden	Lake Norden, SD	Lifescan Labs of Illinois	Skokie	Laboratory	13
14			Avantara Long Grove	Long Grove				14
15			Avantara Milbank	Milbank, SD				15
16			Avantara Mountainview	Rapid City, SD				16
17			Avantara North	Rapid City, SD				17
18			Avantara Norton	Sioux Falls, SD				18
19			Avantara Park Ridge	Park Ridge				19
20			Avantara Pierre	Pierre, SD				20
21			Avantara Redfield	Redfield, SD				21
22			Avantara Salem	Salem, SD				22
23			Avantara St. Cloud	Rapid City, SD				23
24			Avantara Watertown	Watertown, SD				24
25			Bella Terra Streamwood	Streamwood				25
26			Bella Terra Wheeling	Wheeling				26
27			Carlton Skilled Nursing Facility LLC	Chicago				27
28			Chalet Skilled Nursing Facility LLC	Chicago				28
29			Clark Skilled Nursing Facility	Chicago				29
30			Elmbrook Skilled Nursing Facility LLC	Elmhurst				30

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Evanston Skilled Nursing Facility LLC	Evanston				1
2			Grove at the Lake Skilled Nursing Facility LLC	Zion				2
3			Grove of Berwyn	Berwyn				3
4			Grove of Fox Valley	Aurora				4
5			Grove of St. Charles	St. Charles				5
6			Lagrange Skilled Nursing Facility LLC	Lagrange Park				6
7			Lakefront Skilled Nursing Facility LLC	Chicago				7
8			Lincoln Park Skilled Nursing Facility LLC	Chicago				8
9			Lincolnshire Living & Rehab Center LLC	Lincolnshire				9
10			Northbrook Skilled Nursing Facility LLC	Northbrook				10
11			Peterson Park Associates Limited Partnership	Chicago				11
12			Skokie Skilled Nursing Facility LLC	Skokie				12
13			Valley Skilled Nursing Facility	Billings, MT				13
14			Warren Barr Living And Rehab	Chicago				14
15			Warren Barr North Shore	Highland Park				15
16			Warren Barr South Loop	Chicago				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietician Salary	$	Legacy Healthcare Financial Services		$ 3,999	$ 3,999	15
16	V	01	Dietary Supplies		Legacy Healthcare Financial Services		21	21	16
17	V	02	Food		Legacy Healthcare Financial Services		7,649	7,649	17
18	V	03	Housekeeping		Legacy Healthcare Financial Services		2,607	2,607	18
19	V	04	Linen Replacement		Legacy Healthcare Financial Services		177	177	19
20	V	06	Maintenance Salary		Legacy Healthcare Financial Services		12,337	12,337	20
21	V	06	Repairs & Maintenance		Legacy Healthcare Financial Services		732	732	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services		102,114	102,114	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services		9,638	9,638	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services		21,938	21,938	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services		6,956	6,956	25
26	V	11	Activities Program		Legacy Healthcare Financial Services		10	10	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services		27	27	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services		77,741	77,741	28
29	V	19	Professional Fees	210,000	Legacy Healthcare Financial Services		25,522	(184,478)	29
30	V	20	Dues / Licenses / Permits		Legacy Healthcare Financial Services		4,358	4,358	30
31	V	21	Clerical & General Wages		Legacy Healthcare Financial Services		313,671	313,671	31
32	V	21	Clerical & Office Expense		Legacy Healthcare Financial Services		22,873	22,873	32
33	V	24	Education & Seminars		Legacy Healthcare Financial Services		174	174	33
34	V	25	Travel		Legacy Healthcare Financial Services		5,812	5,812	34
35	V	26	Insurance - General		Legacy Healthcare Financial Services		153	153	35
36	V	27	Non-Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		31,159	31,159	36
37	V	34	Rent		Legacy Healthcare Financial Services		39,343	39,343	37
38	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services		121	121	38
39	Total			$ 210,000			$ 689,135	$ * 479,135	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Equipment Rental		Legacy Healthcare Financial Services		525	$ 525	15
16	V	35	Auto Rental		Legacy Healthcare Financial Services		5,121	5,121	16
17	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services		7,244	7,244	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			$			$ 12,889	$ * 12,889	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	CF St. Louis LLC		$ 1,360	$ 1,360	15
16	V	6	Repairs & Maintenance		CF St. Louis LLC		1,318	1,318	16
17	V	19	Property Valuation Fee		CF St. Louis LLC		466	466	17
18	V	19	Accounting Fees		CF St. Louis LLC		106	106	18
19	V	20	Dues & Subscriptions		CF St. Louis LLC		1	1	19
20	V	21	Office Expense		CF St. Louis LLC		316	316	20
21	V	26	Insurance		CF St. Louis LLC		341	341	21
22	V	30	Depreciation		CF St. Louis LLC		8,387	8,387	22
23	V	32	Interest Expense		CF St. Louis LLC		4,713	4,713	23
24	V	33	Real Estate Taxes		CF St. Louis LLC		4,282	4,282	24
25	V								25
26	V	34	Rent	39,343	CF St. Louis LLC			(39,343)	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			$ 39,343			$ 21,289	$ * (18,054)	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Medical Supplies	$ 8,250	ReMED Services		$ 5,763	$ (2,487)	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			$ 8,250			$ 5,763	$ * (2,487)	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 25,341	ProPay HR LLC		$ 19,535	$ (5,806)	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			$ 25,341			$ 19,535	$ * (5,806)	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$ 18,000	ML Group Design & Development		$ 17,559	$ (441)	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			$ 18,000			$ 17,559	$ * (441)	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry	$ 119,175	EcoBrite Linen		$ 119,175	$	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			$ 119,175			$ 119,175	$ *	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 26,440	Lifescan Labs of Illinois		$ 15,679	$ (10,761)	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			$ 26,440			$ 15,679	$ * (10,761)	39

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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	$		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 Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X]

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

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

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietician Salary	Available Bed Days	2,540,133	53	$ 130,303	$ 130,303	77,958	$ 3,999	1
2	01	Dietary Supplies	Available Bed Days	2,540,133	53	697		77,958	21	2
3	02	Food	Available Bed Days	2,540,133	53	249,220		77,958	7,649	3
4	03	Housekeeping	Available Bed Days	2,540,133	53	84,952		77,958	2,607	4
5	04	Linen Replacement	Available Bed Days	2,540,133	53	5,771		77,958	177	5
6	06	Maintenance Salary	Available Bed Days	2,540,133	53	401,986	401,986	77,958	12,337	6
7	06	Repairs & Maintenance	Available Bed Days	2,540,133	53	23,857		77,958	732	7
8	10	Nursing Salary	Available Bed Days	2,540,133	53	3,327,223	3,327,223	77,958	102,114	8
9	10	Nurse/Medical Director Consultan	Available Bed Days	2,540,133	53	314,035		77,958	9,638	9
10	10	Medical Supplies	Available Bed Days	2,540,133	53	714,824		77,958	21,938	10
11	12	Social Service Salary	Available Bed Days	2,540,133	53	226,662	226,662	77,958	6,956	11
12	11	Activities Program	Available Bed Days	2,540,133	53	335		77,958	10	12
13	12	Social Service Consultant	Available Bed Days	2,540,133	53	893		77,958	27	13
14	17	COO / Administrative Salary	Available Bed Days	2,540,133	53	2,533,078	2,533,078	77,958	77,741	14
15	19	Professional Fees	Available Bed Days	2,540,133	53	831,592		77,958	25,522	15
16	20	Dues / Licenses / Permits	Available Bed Days	2,540,133	53	141,983		77,958	4,358	16
17	21	Clerical & General Wages	Available Bed Days	2,540,133	53	10,220,453	10,220,453	77,958	313,671	17
18	21	Clerical & Office Expense	Available Bed Days	2,540,133	53	745,293		77,958	22,873	18
19	24	Education & Seminars	Available Bed Days	2,540,133	53	5,655		77,958	174	19
20	25	Travel	Available Bed Days	2,540,133	53	189,364		77,958	5,812	20
21	26	Insurance - General	Available Bed Days	2,540,133	53	4,997		77,958	153	21
22	27	Non-Nursing Payroll Taxes / Bene	Available Bed Days	2,540,133	53	1,015,274		77,958	31,159	22
23	34	Rent	Available Bed Days	2,540,133	53	1,281,940		77,958	39,343	23
24	34	Offsite Storage / Parking	Available Bed Days	2,540,133	53	3,949		77,958	121	24
25	TOTALS					$ 22,454,338	$ 16,839,706		$ 689,135	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Legacy Healthcare Financial Services
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 679-9797
Fax Number: (847) 683-2900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Equipment Rental	Available Bed Days	2,540,133	53	17,109		77,958	525	1
2	35	Auto Rental	Available Bed Days	2,540,133	53	166,843		77,958	5,121	2
3	15	Nursing Payroll Taxes / Benefits	Available Bed Days	2,540,133	53	236,021		77,958	7,244	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					$ 419,973	$		$ 12,889	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: CF St. Louis LLC
Street Address: 3450 Oakton Street
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 676-5300
Fax Number: (847) 676-5348

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Available Bed Days	2,540,133	53	$ 44,301	$	77,958	$ 1,360	1
2	6	Repairs & Maintenance	Available Bed Days	2,540,133	53	42,932		77,958	1,318	2
3	19	Property Valuation Fee	Available Bed Days	2,540,133	53	15,181		77,958	466	3
4	19	Accounting Fees	Available Bed Days	2,540,133	53	3,453		77,958	106	4
5	20	Dues & Subscriptions	Available Bed Days	2,540,133	53	23		77,958	1	5
6	21	Office Expense	Available Bed Days	2,540,133	53	10,298		77,958	316	6
7	26	Insurance	Available Bed Days	2,540,133	53	11,124		77,958	341	7
8	30	Depreciation	Available Bed Days	2,540,133	53	273,261		77,958	8,387	8
9	32	Interest Expense	Available Bed Days	2,540,133	53	153,558		77,958	4,713	9
10	33	Real Estate Taxes	Available Bed Days	2,540,133	53	139,524		77,958	4,282	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					$ 693,655	$		$ 21,289	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMED Services LLC
Street Address: 3424 Oakton Street, Suite 102
City / State / Zip Code: Skokie, IL
Phone Number: (847) 440-2600
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			$	$		$ 5,763	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					$	$		$ 5,763	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: ((847) 905 3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 19,535	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					$	$		$ 19,535	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ML Group Design and Development
Street Address: 3424 Oakton St
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 676-5300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			$	$		$ 17,559	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					$	$		$ 17,559	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	04	Laundry	Direct			$	$		$ 119,175	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					$	$		$ 119,175	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lifescan Labs of Illinois, LLC
Street Address: 5255 Golf Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663-8300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 15,679	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					$	$		$ 15,679	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	HUD Loan		X	Mortgage			$	$ 23,280,553			$ 849,259	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Line of Credit				64,036			13,658	6
7	Allocated from CF St. Louis		X								4,713	7
8												8
9	TOTAL Facility Related						$	$ 23,344,589			$ 867,630	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,441)	10
11	Interest Income - Bldg Co.		X								(1,539)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,980)	14
15	TOTALS (line 9+line14)						$	$ 23,344,589			$ 857,650	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 131,865 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.)

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 438,699	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.)		$ 583,208	2
3. Under or (over) accrual (line 2 minus line 1).		$ 144,509	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 732,375	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.)		$ 29,228	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.		$ 906,112	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	711,797	8
	2016	571,818	9
	2017	578,156	10
	2018	589,439	11
	2019	578,926	12

2020 Accrual = $697,501 (full tax bill amount) x 1.05 = $732,375

Allocated from CF St. Louis LLC: $4,282

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bella Terra Morton Grove COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053223

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-19-120-002-0000	Long Term Care Facility	$ 655,168.89	$ 543,790.18
2.	10-19-303-064-0000	Long Term Care Facility	$ 19,487.13	$ 16,174.32
3.	10-19-200-011-0000	Long Term Care Facility	$ 22,844.82	$ 18,961.20
4.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,282.06
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,157,033.28	$ 583,207.76

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bella Terra Morton Grove COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053223

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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 [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	183,600	2014	$ 866,800	1
2	Allocated from CF St. Louis, LLC			6,057	2
3	TOTALS	183,600		$ 872,857	3

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	213		2014	1965	$ 14,163,360	$ 355,751	40	$ 354,084	$ (1,667)	$ 2,186,775	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2015	315,220		20	15,761	15,761	94,566	9
10	Various			2016	283,536		20	14,177	14,177	70,884	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

*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 Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		285,064	7,732		13,554	5,823	60,638	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 15,047,180	$ 363,483		$ 397,576	$ 34,093	$ 2,412,863	70

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,047,180	$ 363,483		$ 397,576	$ 34,093	$ 2,412,863	1
2	Landscaping Enhancements - Outside Facility	2017	21,267		20	1,063	1,063	4,253	2
3	Arcitect Fee 500 Wing And Exterior Renovation	2017	19,345		20	967	967	3,869	3
4	Flooring - 900 Wing Dining Room	2017	5,417		20	271	271	1,083	4
5	Remove Diverting Valve Boiler And Install Isolation Valve	2017	8,232		20	412	412	1,646	5
6	Replace Concrete, Wallcovering, Flooring. Paint/Install - Activity	2017	40,600		20	2,030	2,030	8,120	6
7	New Block Heater And Water Pump/Thermostat Housing	2017	22,187		20	1,109	1,109	4,437	7
8	Electrial Work To Correct Life Safety Inspection	2017	2,875		20	144	144	575	8
9	Interior And Exterior Permits	2017	2,638		20	132	132	528	9
10	Paving - Outside Facility	2017	2,600		20	130	130	520	10
11	Landscaping Enhancements - Outside Facility	2017	2,800		20	140	140	560	11
12	Plumbing And Sewer	2017	6,400		20	320	320	1,280	12
13	Repair Storm Drains And Brickwork	2017	4,250		20	213	213	850	13
14	Relocate Exhaust Fan	2017	3,110		20	156	156	622	14
15	Kitchen Floor Tiles Grinded Out. Grout Was Replaced	2018	7,850		20	393	393	1,178	15
16	Resident Bathrooms Grab Bars In Wing 200,300,400.	2018			20				16
17	New Faucets Wing 300, Entire Wing 200 Had New Faucet	2018			20				17
18	Handles And Carthriges. Wing 200,300,400,496 And	2018			20				18
19	Terrace Suits South All Had Under Sink Scald Pipe.	2018	3,650		20	183	183	548	19
20	Dialysis Room-Demolition Of Walls, Drywall, Sprinkler,	2018			20				20
21	Counters Quartz, Plumbing Lines And Drains, Flooring Vinyl	2018			20				21
22	Electric New Outlets,4 New Lighting Fixtures, Millwork On	2018			20				22
23	Cabinets.	2018	50,000		20	2,500	2,500	7,500	23
24	Roof-Repaired Bad Leaks In 100 Wing, Patched 2 Large	2018			20				24
25	Areas In 400 Wing With Hot Tar, Sealed And Repaired Large	2018			20				25
26	Open Cracks Around Dome Area.	2018	3,125		20	156	156	469	26
27	Arcitect Fee 500 Wing And Exterior Renovation	2018	3,037		20	152	152	456	27
28	Roof Carlisle Sure-Weld 60 Tpo Roof System Install And Materia	2019	81,105		20	4,055	4,055	8,111	28
29	Plumbing To 6 Dialysis Stations	2019	5,995		20	300	300	600	29
30	119966 Kit, Energy 1500 Tp 1200M 16Cc Bg400	2019	14,162		20	708	708	1,416	30
31	Replace Electrical Panels And Circuit Breakers	2019	6,729		20	336	336	673	31
32	Run 200 Ft Of 2" Copper Pipe Up And Over Bldg ($6,600)	2020	6,438		20	322	322	322	32
33	Cinder Block Retaining Wall ($17,950)	2020	17,510		20	876	876	876	33
34	TOTAL (lines 1 thru 33)		$ 15,388,502	$ 363,483		$ 414,642	$ 51,160	$ 2,463,353	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 15,388,502	$ 363,483		$ 414,642	$ 51,160	$ 2,463,353	1
2	Compressor Machine Flush, Chiller Repair - Fittings For Heat Ex	2020	3,683		20	184	184	184	2
3	Install Chiller Condenser Heat Exchanger In Chiller Rm ($18,400	2020	17,949		20	897	897	920	3
4	Carpet ($3,618)	2020	3,529		20	176	176	176	4
5	Dialysis Rm Upgrade - Flooring, Painting ($5,825)	2020	5,682		20	284	284	284	5
6	Remove Concrete And Remove Curve ($5,875)	2020	5,731		20	287	287	287	6
7	Roof Repairs, Tuckpointing ($2,979)	2020	2,906		20	145	145	145	7
8	Roofing Sheeting & Seal Coat ($3,225)	2020	3,146		20	157	157	157	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,431,130	$ 363,483		$ 416,774	$ 53,291	$ 2,465,507	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,431,130	$ 363,483		$ 416,774	$ 53,291	$ 2,465,507	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 15,431,130	$ 363,483		$ 416,774	$ 53,291	$ 2,465,507	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 15,431,130	$ 363,483		$ 416,774	$ 53,291	$ 2,465,507	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
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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)		$ 15,431,130	$ 363,483		$ 416,774	$ 53,291	$ 2,465,507	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Party								1
2	Buildings:								2
3	Allocated from CF St. Louis, LLC	2016	32,614	1,514	35	932	(582)	4,659	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	202,487	4,995	20	10,124	5,129	50,622	9
10	Allocated from CF St. Louis, LLC	2017	4,700	116	20	235	119	940	10
11	Allocated from CF St. Louis, LLC	2019	42,598	1,051	20	2,130	1,079	4,260	11
12	Allocated from CF St. Louis, LLC	2019	2,240	55	20	112	57	112	12
13									13
14	Allocated from Legacy HC	2018	242		20	12	12	36	14
15	Allocated from Legacy HC	2020	183		20	9	9	9	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)		$ 285,064	$ 7,732		$ 13,554	$ 5,823	$ 60,638	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 285,064	$ 7,732		$ 13,554	$ 5,823	$ 60,638	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 285,064	$ 7,732		$ 13,554	$ 5,823	$ 60,638	34

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 24,728	$ 653	$ 2,473	$ 1,820	10	$ 9,188	71
72	Current Year Purchases	55,792	2	5,579	5,577	10	5,579	72
73	Fully Depreciated Assets	1,681,007				10	1,681,007	73
74								74
75	TOTALS	$ 1,761,528	$ 655	$ 8,052	$ 7,397		$ 1,695,774	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)	$ 18,065,515	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 364,138	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 424,826	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 60,688	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,161,281	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 Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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 from Legacy Healthcare				121			5
6								6
7	TOTAL				$ 121 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,255 Description: See Attached
(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	Allocated from Legacy Healthcare		$	$ 5,121	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,121	21

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

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 366,783	$		$ 366,783	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			116,163			116,163	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			560,135			560,135	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				233,316		233,316	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			14,799		76,839	129,819		221,457	13
14	TOTAL			$ 14,799		$ 1,119,920	$ 363,135		$ 1,497,854	14

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

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100,522	$ 1,892,158	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	557,791	557,791	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		14,189	6
7	Other Prepaid Expenses	340,530	340,530	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	325,694	750,496	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,324,537	$ 3,555,164	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	86,304	1,186,304	13
14	Buildings, at Historical Cost		17,720,000	14
15	Leasehold Improvements, at Historical Cost	1,093,947	1,493,947	15
16	Equipment, at Historical Cost	695,101	2,065,101	16
17	Accumulated Depreciation (book methods)	(536,007)	(4,758,095)	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): See Attached	2,418,522	4,779,090	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,757,867	$ 22,486,347	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,082,404	$ 26,041,511	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,185,229	$ 1,185,230	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	64,036	64,036	29
30	Accrued Salaries Payable	248,837	248,837	30
31	Accrued Taxes Payable (excluding real estate taxes)	244,090	244,090	31
32	Accrued Real Estate Taxes(Sch.IX-B)		732,375	32
33	Accrued Interest Payable		81,482	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,182,765	2,182,854	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,924,957	$ 4,738,904	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,280,553	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,465,233	1,063,559	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,465,233	$ 24,344,112	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,390,190	$ 29,083,016	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 692,214	$ (3,041,505)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,082,404	$ 26,041,511	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 921,365	1
2	Restatements (describe):		2
3	Equity Restatement	(846)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 920,519	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(228,305)	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)**	$ (228,305)	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)**	$ 692,214	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,695,541	1
2	Discounts and Allowances for all Levels	(5,188,155)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,507,386	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,044,341	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,044,341	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,578	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,828	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,366	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 273,772	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,441	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,441	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,420,513	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,420,513	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,254,453	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,700,179	31
32	Health Care	5,565,969	32
33	General Administration	2,494,219	33
	B. Capital Expense		
34	Ownership	2,133,638	34
	C. Ancillary Expense		
35	Special Cost Centers	2,190,411	35
36	Provider Participation Fee	398,342	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,482,758	40
41	**Income before Income Taxes (line 30 minus line 40)****	(228,305)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (228,305)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,218,952	44
45	Private Pay - Net Inpatient Revenue	1,495,516	45
46	Medicare - Net Inpatient Revenue	1,611,788	46
47	Other-(specify) Insurance	181,130	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,507,386	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,046	2,278	$ 118,459	$ 52.00	1
2	Assistant Director of Nursing	2,123	2,301	104,385	45.37	2
3	Registered Nurses	33,137	37,454	1,358,046	36.26	3
4	Licensed Practical Nurses	35,388	44,057	1,461,158	33.17	4
5	CNAs & Orderlies	57,193	73,687	1,340,580	18.19	5
6	CNA Trainees					6
7	Licensed Therapist	417	449	14,799	32.96	7
8	Rehab/Therapy Aides	5,517	6,533	100,562	15.39	8
9	Activity Director	2,024	2,160	42,188	19.53	9
10	Activity Assistants	11,428	12,729	170,956	13.43	10
11	Social Service Workers	7,717	8,258	209,011	25.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,629	6,025	148,992	24.73	17
18	Housekeepers	7	7	87	12.43	18
19	Laundry	5,786	6,088	74,394	12.22	19
20	Administrator	1,992	2,235	115,820	51.82	20
21	Assistant Administrator	2,104	2,192	72,248	32.96	21
22	Other Administrative					22
23	Office Manager	1,992	2,160	58,604	27.13	23
24	Clerical	4,831	5,231	91,486	17.49	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	1,248	1,391	30,921	22.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	8,027	8,614	133,510	15.50	33
34	TOTAL (lines 1 - 33)	188,606	223,849	$ 5,646,206 *	$ 25.22	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,297,735	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	43,256	10-03	38
39	Pharmacist Consultant	Monthly	5,450	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,189	11-03	44
45	Social Service Consultant	Monthly	4,001	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	1,050	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 1,366,681		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alicia Wildermuth	Administrator	0	$ 115,820
Emilio Benitez	Assistant Admin	0	72,248
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 188,068

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 24,000
ProPay HR	Payroll Processing	25,341
Onyx Procurement Solutions	Procurement Services	11,870
Legacy HC Financial Services	Clerical Services	210,000
Achieve Accreditation	Accreditation	8,464
Compliagent	Compliance	1,961
PatientPing, Inc.	Care Collaboration Software	18,000
Personnel Planners	Unemployment Tax Consultant	1,800
Cortex Health Care	Data Processing	10,670
Telemedicine Solutions	Risk Prevention Software	7,048
See Attached	Legal	112,254
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 431,409

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 136,873
Unemployment Compensation Insurance	25,794
FICA Taxes	431,935
Employee Health Insurance	135,410
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	28,789
401K Expense	14,311
Voluntary Benefit Contributions	13,640
Employee Physical Exams	6,360
TOTAL (agree to Schedule V, line 22, col.8)	$ 793,112

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	400
Health Care Worker Background Check	
(Indicate # of checks performed 99)	994
Patient Background Checks 489	4,892
Dues & Subscriptions	30,144
Licenses & Fees	2,861
See Supplemental Schedule	4,358
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,639

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	193
See Supplemental Schedule	174
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 367

* Attach copy of IMRF notifications

**See instructions.

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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? **Yes**
If YES, give association name and amount. **HCCI - $29,819, IHCA - $17,250**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,183** Line **10**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **398,342**
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? **Yes**

(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. $ 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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

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