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: 0055954

Facility Name: Bella Terra Streamwood

Address: 815 E Irving Park Rd (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9028

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2019

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847)517-7067

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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	214	Skilled (SNF)	214	78,324	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,324	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	38,797	1,664	6,159	46,620	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,797	1,664	6,159	46,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.52%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 9/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 3,972

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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	425,641	89,287	2,400	517,328		517,328	2,799	520,127			1
2	Food Purchase		360,491		360,491		360,491	7,685	368,176			2
3	Housekeeping	321,321	35,776	-	357,097		357,097	2,619	359,716			3
4	Laundry	68,164	19,877	-	88,041		88,041	178	88,219			4
5	Heat and Other Utilities			230,231	230,231		230,231	1,366	231,597			5
6	Maintenance	70,115	96,804	206,529	373,448		373,448	29,174	402,622			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	885,241	602,235	439,160	1,926,636		1,926,636	43,821	1,970,457			8
	B. Health Care and Programs											
9	Medical Director	-	-	24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	4,345,116	220,815	76,835	4,642,766		4,642,766	134,318	4,777,084			10
10a	Therapy	49,878	-	-	49,878		49,878		49,878			10a
11	Activities	138,385	4,479	2,901	145,765		145,765	10	145,775			11
12	Social Services	146,536	-	5,264	151,800		151,800	7,017	158,817			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	25,538	25,538		25,538		25,538			14
15	Other (specify):* Alloc. Mgmt. Bene	-	-	-				7,278	7,278			15
16	TOTAL Health Care and Programs	4,679,915	225,294	134,538	5,039,747		5,039,747	148,623	5,188,370			16
	C. General Administration											
17	Administrative	179,428	-	681,603	861,031		861,031	(603,496)	257,535			17
18	Directors Fees			-								18
19	Professional Services			223,843	223,843		223,843	33,978	257,821			19
20	Dues, Fees, Subscriptions & Promotions			90,593	90,593		90,593	(19,656)	70,937			20
21	Clerical & General Office Expenses	401,915	-	252,913	654,828		654,828	338,517	993,345			21
22	Employee Benefits & Payroll Taxes			828,525	828,525		828,525		828,525			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			2,979	2,979		2,979	174	3,153			24
25	Other Admin. Staff Transportation		-	-				5,839	5,839			25
26	Insurance-Prop.Liab.Malpractice			310,200	310,200		310,200	497	310,697			26
27	Other (specify):* Alloc. Mgmt. Bene			-				31,306	31,306			27
28	TOTAL General Administration	581,343		2,390,656	2,971,999		2,971,999	(212,841)	2,759,158			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,146,499	827,529	2,964,354	9,938,382		9,938,382	(20,397)	9,917,985			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 Streamwood #0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,817	36,817		36,817	428,276	465,093			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			97,461	97,461		97,461	(467)	96,994			32
33	Real Estate Taxes			733,168	733,168		733,168	(102,627)	630,541			33
34	Rent-Facility & Grounds			983,927	983,927		983,927	(944,277)	39,650			34
35	Rent-Equipment & Vehicles			52,185	52,185		52,185	5,673	57,858			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			1,903,558	1,903,558		1,903,558	(613,422)	1,290,136			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	350,440	1,129,583	1,480,023		1,480,023		1,480,023			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			384,608	384,608		384,608		384,608			42
43	Other (specify):* Non-Allowable Cos	47,679	-	402,102	449,781		449,781	(449,781)				43
44	**TOTAL Special Cost Centers**	47,679	350,440	1,916,293	2,314,412		2,314,412	(449,781)	1,864,631			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,194,178	1,177,969	6,784,205	14,156,352		14,156,352	(1,083,600)	13,072,752			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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,438)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1	30		9
10	Interest and Other Investment Income	(5,202)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,240)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(228)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,723)	43		18
19	Entertainment	(256)	43		19
20	Contributions	(2,584)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(264,180)	43		24
25	Fund Raising, Advertising and Promotional	(10,731)	43		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 See PG5A	(424,934)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (732,515)		$	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)	(351,085)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (351,085)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,083,600)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Bella Terra Streamwood

ID# 0055954

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (52,802)	43	1
2	X-Rays - Part A	(24,651)	43	2
3	Consolidated Billing charges	(471)	43	3
4	Sequestration Expense	(23,038)	43	4
5	Lobbying	(24,035)	20	5
6	Non-allowable legal	(290)	19	6
7	Admissions directors salary	(47,679)	43	7
8	Amortization Goodwill	(233,106)	36	8
9	Rent Expense	(18,862)	34	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(424,934)		49

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 983,927	Streamwood Property Holdings, LLC	100%	$ 18,862	$ (965,065)	1
2	V	33	Property Taxes	733,168	Streamwood Property Holdings, LLC	100%	626,239	(106,929)	2
3	V	21	Filing Fees		Streamwood Property Holdings, LLC	100%	74	74	3
4	V	19	Professional Fees - Accounting		Streamwood Property Holdings, LLC	100%	16,050	16,050	4
5	V	30	Depreciation		Streamwood Property Holdings, LLC	100%	413,267	413,267	5
6	V	36	Amortization Goodwill		Streamwood Property Holdings, LLC	100%	233,106	233,106	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,717,095			$ 1,307,598	$ * (409,497)	14

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary	$	Legacy Healthcare Financial Services	100%	$ 4,018	$ 4,018	15
16	V	1	Dietary Supplies		Legacy Healthcare Financial Services	100%	21	21	16
17	V	2	Food		Legacy Healthcare Financial Services	100%	7,685	7,685	17
18	V	3	Housekeeping		Legacy Healthcare Financial Services	100%	2,619	2,619	18
19	V	4	Linen Replacement		Legacy Healthcare Financial Services	100%	178	178	19
20	V	6	Maintenance Salary		Legacy Healthcare Financial Services	100%	12,395	12,395	20
21	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services	100%	736	736	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services	100%	102,594	102,594	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services	100%	9,683	9,683	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services	100%	22,041	22,041	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services	100%	6,989	6,989	25
26	V	11	Activities Program		Legacy Healthcare Financial Services	100%	10	10	26
27	V	12	Social Service Consultant		Legacy Healthcare Financial Services	100%	28	28	27
28	V	17	COO / Administrative Salary		Legacy Healthcare Financial Services	100%	24,576	24,576	28
29	V	17	Administrative (Non-Owner)	681,603	Legacy Healthcare Financial Services	100%	53,531	(628,072)	29
30	V	19	Propay Fees		Legacy Healthcare Financial Services	100%	956	956	30
31	V	19	Accounting Fees		Legacy Healthcare Financial Services	100%	1,088	1,088	31
32	V	19	Legal / Other Professional Fees		Legacy Healthcare Financial Services	100%	23,598	23,598	32
33	V	20	License / Dues / Permits		Legacy Healthcare Financial Services	100%	4,378	4,378	33
34	V	21	A&G Wages		Legacy Healthcare Financial Services	100%	315,144	315,144	34
35	V	21	Office Expenses		Legacy Healthcare Financial Services	100%	22,981	22,981	35
36	V	24	Education & Seminars		Legacy Healthcare Financial Services	100%	174	174	36
37	V	25	Travel		Legacy Healthcare Financial Services	100%	5,839	5,839	37
38	V	26	Insurance - General		Legacy Healthcare Financial Services	100%	154	154	38
39	Total			$ 681,603			$ 621,416	$ * (60,187)	39

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Non-Nursing Payroll Taxes / Benefits	$	Legacy Healthcare Financial Services	100%	$ 31,306	$ 31,306	15
16	V	34	Rent Expense		Legacy Healthcare Financial Services	100%	39,528	39,528	16
17	V	34	Offsite Storage / Parking		Legacy Healthcare Financial Services	100%	122	122	17
18	V	35	Equipment Rental		Legacy Healthcare Financial Services	100%	528	528	18
19	V	35	Auto Rental		Legacy Healthcare Financial Services	100%	5,145	5,145	19
20	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services	100%	7,278	7,278	20
21	V	30	Depreciation Expense		Legacy Healthcare Financial Services	100%	1,003	1,003	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			$			$ 84,910	$ * 84,910	39

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CF ST. LOUIS, LLC	100%	$ 1,366	$ 1,366	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100%	1,324	1,324	16
17	V	19	PROPERTY VALUATION FEES		CF ST. LOUIS, LLC	100%	468	468	17
18	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100%	106	106	18
19	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100%	1	1	19
20	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100%	318	318	20
21	V	26	INSURANCE		CF ST. LOUIS, LLC	100%	343	343	21
22	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	8,426	8,426	22
23	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100%	4,735	4,735	23
24	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100%	4,302	4,302	24
25	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	5,579	5,579	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			$			$ 26,968	$ * 26,968	39

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs and Maintenance	$ 13,500	ReMed Services, LLC		$ 28,219	$ 14,719	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			$ 13,500			$ 28,219	$ * 14,719	39

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 34,911	ProPay HR LLC		$ 26,913	$ (7,998)	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			$ 34,911			$ 26,913	$ * (7,998)	39

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Gpn Family Trust U/A/D 4/28/08	42.5	Astoria Place	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Doros Generation Trust U/A/D 1/3/12	42.5	Aurora, Avantara	Aurora	Financial Srvcs, LLC			2
3	Oakway Operations, LLC	15	Berwyn, The Grove of	Berwyn				3
4			Bethany Terrace	Morton Grove	Legacy Real	Skokie	Real Estate	4
5			Carlton at the Lake	Chicaog	Properties, LLC			5
6			Chalet Living & Rehab	Chicago				6
7			Clark Skilled Nursing Facility	Chicago	Grove Healthcare	Skokie	Real Estate	7
8			Elmhurst, The Grove of	Elmhurst	Properties, LLC			8
9			Elgin, Avantara	Elgin				9
10			Evanston, The Grove of	Evanston	ReMED Services,	Skokie	Medical	10
11			Evergreen Park, Avantara	Evergreen Park	LLC		Equipment Sales	11
12			Fox Valley, The Grove of	Aurora				12
13			LaGrange, The Grove of	LaGrange Park	Progressive	Skokie	Consulting	13
14			Lake, The Grove at	Zion	Healthcare			14
15			Lakefront	Chicago	Consulting			15
16			Lincoln Park, Warren Barr	Chicago				16
17			Lincolnshire, Warren Barr	Lincolnshire	MG Property	Morton Grove	Real Estate	17
18			Long Grove, Avantara	Long Grove	Holdings, LLC			18
19			Northbrook, The Grove of	Northbrook				19
20			North Shore, Warren Barr	Highland Park	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21			Park Ridge, Avantara	Park Ridge				21
22			Peterson Park	Chicago	ProPay	Evanston	Payroll Services	22
23			Skokie, The Grove of	Skokie				23
24			South Loop, Warren Barr	Chicago	ML Group Design	Skokie	Asset Mgmt Fees	24
25			St. Charles, The Grove of	St. Charles				25
26			Streamwood, Bella Terra	Streamwood	ML Enterprise	Skokie	Asset Mgmt Fees	26
27			Terrace Gardens	Chicago				27
28			Vistas Fox Valley	Aurora	CF St.Louis Inc	Skokie	Management Co.	28
29			Warren Barr	Chicago				29
30			Wellshire	Lincolnshire	Streamwood Property	Skokie	Real Estate	30

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Wheeling, Bella Terra	Wheeling				1
2								2
3			Arlington, Avantara (South Dakota)	South Dakota				3
4			Armour, Avantara (South Dakota)	South Dakota				4
5			Arrowhead, Avantara (South Dakota)	South Dakota				5
6			Billings, Avantara (Montana)	Montana				6
7			Clark, Avantara (South Dakota)	South Dakota				7
8			Groton, Avantara (South Dakota)	South Dakota				8
9			Huron, Avantara (South Dakota)	South Dakota				9
10			Huron-Wellshire (South Dakota)	South Dakota				10
11			Ipswich, Avantara (South Dakota)	South Dakota				11
12			Lake Norden, Avantara (South Dakota)	South Dakota				12
13			Milbank, Avantara (South Dakota)	South Dakota				13
14			Mountainview, Avantara (South Dakota)	South Dakota				14
15			North, Avantara (South Dakota)	South Dakota				15
16			Norton, Avantara (South Dakota)	South Dakota				16
17			Park Place, Wellshire (South Dakota)	South Dakota				17
18			Pierre, Avantara (South Dakota)	South Dakota				18
19			Redfield, Avantara (South Dakota)	South Dakota				19
20			Salem, Avantara (South Dakota)	South Dakota				20
21			St. Cloud, Avantara (South Dakota)	South Dakota				21
22			St. George, Bella Terra (Utah)	Utah				22
23			Valley SNF, Bella Terra (Montana)	Montana				23
24			Watertown, Avantara (South Dakota)	South Dakota				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	No owners from this facility received any compensation.										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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	1	Dietician Salary	AVAIL. BED DAYS	2,540,133	53	$ 130,303	$ 130,303	78,324	$ 4,018	1
2	1	Dietary Supplies	AVAIL. BED DAYS	2,540,133	53	697		78,324	21	2
3	2	Food	AVAIL. BED DAYS	2,540,133	53	249,220		78,324	7,685	3
4	3	Housekeeping	AVAIL. BED DAYS	2,540,133	53	84,952		78,324	2,619	4
5	4	Linen Replacement	AVAIL. BED DAYS	2,540,133	53	5,771		78,324	178	5
6	6	Maintenance Salary	AVAIL. BED DAYS	2,540,133	53	401,986	401,986	78,324	12,395	6
7	6	Repairs & Maintenance	AVAIL. BED DAYS	2,540,133	53	23,857		78,324	736	7
8	10	Nursing Salary	AVAIL. BED DAYS	2,540,133	53	3,327,223	3,327,223	78,324	102,594	8
9	10	Nurse/Medical Director Consultan	AVAIL. BED DAYS	2,540,133	53	314,035		78,324	9,683	9
10	10	Medical Supplies	AVAIL. BED DAYS	2,540,133	53	714,824		78,324	22,041	10
11	12	Social Service Salary	AVAIL. BED DAYS	2,540,133	53	226,662	226,662	78,324	6,989	11
12	11	Activities Program	AVAIL. BED DAYS	2,540,133	53	335		78,324	10	12
13	12	Social Service Consultant	AVAIL. BED DAYS	2,540,133	53	893		78,324	28	13
14	17	COO / Administrative Salary	AVAIL. BED DAYS	2,540,133	53	797,017	797,017	78,324	24,576	14
15	17	Administrative (Non-Owner)	AVAIL. BED DAYS	2,540,133	53	1,736,060		78,324	53,531	15
16	19	Propay Fees	AVAIL. BED DAYS	2,540,133	53	31,002		78,324	956	16
17	19	Accounting Fees	AVAIL. BED DAYS	2,540,133	53	35,278		78,324	1,088	17
18	19	Legal / Other Professional Fees	AVAIL. BED DAYS	2,540,133	53	765,313		78,324	23,598	18
19	20	License / Dues / Permits	AVAIL. BED DAYS	2,540,133	53	141,983		78,324	4,378	19
20	21	A&G Wages	AVAIL. BED DAYS	2,540,133	53	10,220,453	10,220,453	78,324	315,144	20
21	21	Office Expenses	AVAIL. BED DAYS	2,540,133	53	745,293		78,324	22,981	21
22	24	Education & Seminars	AVAIL. BED DAYS	2,540,133	53	5,655		78,324	174	22
23	25	Travel	AVAIL. BED DAYS	2,540,133	53	189,364		78,324	5,839	23
24	26	Insurance - General	AVAIL. BED DAYS	2,540,133	53	4,997		78,324	154	24
25	TOTALS					$ 20,153,173	$ 15,103,644		$ 621,416	25

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	27	Non-Nursing Payroll Taxes / Bene	AVAIL. BED DAYS	2,540,133	53	$ 1,015,274	$	78,324	$ 31,306	1
2	34	Rent Expense	AVAIL. BED DAYS	2,540,133	53	1,281,940		78,324	39,528	2
3	34	Offsite Storage / Parking	AVAIL. BED DAYS	2,540,133	53	3,949		78,324	122	3
4	35	Equipment Rental	AVAIL. BED DAYS	2,540,133	53	17,109		78,324	528	4
5	35	Auto Rental	AVAIL. BED DAYS	2,540,133	53	166,843		78,324	5,145	5
6	15	Nursing Payroll Taxes / Benefits	AVAIL. BED DAYS	2,540,133	53	236,021		78,324	7,278	6
7	30	Depreciation Expense	Direct Allocation						1,003	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					$ 2,721,136	$		$ 84,910	25

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	AVAIL. BED DAYS	2,540,133	34	$ 44,301	$	78,324	$ 1,366	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	2,540,133	34	42,932		78,324	1,324	2
3	19	PROPERTY VALUATION FEES	AVAIL. BED DAYS	2,540,133	34	15,181		78,324	468	3
4	19	PROFESSIONAL FEES	AVAIL. BED DAYS	2,540,133	34	3,453		78,324	106	4
5	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	2,540,133	34	23		78,324	1	5
6	21	OFFICE EXPENSE	AVAIL. BED DAYS	2,540,133	34	10,298		78,324	318	6
7	26	INSURANCE	AVAIL. BED DAYS	2,540,133	34	11,124		78,324	343	7
8	30	DEPRECIATION	AVAIL. BED DAYS	2,540,133	34	273,261		78,324	8,426	8
9	32	INTEREST EXPENSE	AVAIL. BED DAYS	2,540,133	34	153,558		78,324	4,735	9
10	33	REAL ESTATE TAXES	AVAIL. BED DAYS	2,540,133	34	139,524		78,324	4,302	10
11	30	DEPRECIATION	DIRECT						5,579	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	$		$ 26,968	25

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ReMed Services, LLC
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	6	Repairs & Maintenance	Direct Allocation			$	$		$ 28,219	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					$	$		$ 28,219	25

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, IL 60202
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	19	Payroll Services	Direct Allocation			$	$		$ 26,913	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					$	$		$ 26,913	25

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Congressional Bank		X	Line of Credit		9/1/2019	$ 2,412,440	$ 1,216,892	9/1/2020	0.0535	$ 97,461	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National Government Services		X	Medicare AAP		4/30/2020	117,125	117,125	4/30/2022	0.0000	-	6
7												7
8												8
9	TOTAL Facility Related						$ 2,529,565	$ 1,334,017			$ 97,461	9
	B. Non-Facility Related*											
10												10
11								Allocated from			4,735	11
12								Interest Income Offset			(5,202)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (467)	14
15	TOTALS (line 9+line14)						$ 2,529,565	$ 1,334,017			$ 96,994	15

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

* 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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 695,259	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.)	2019	$ 644,634	2
3. Under or (over) accrual (line 2 minus line 1).		$ (50,625)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 676,864	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
	Alloc. Fr. Mgmt. Co.	4,302	
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.		$ 630,541	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	612,375	8
	2016	619,352	9
	2017	664,167	10
	2018		11
	2019	644,634	12

2020 RE Accrual : 644,634 x 1.0500 = 676,864.

	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 Streamwood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055954

CONTACT PERSON REGARDING THIS REPORT Moti Ninio

TELEPHONE (847) 676-5315 FAX #: (773) 248-9703

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.	06-25-300-018-0000	Nursing Home	$ 644,634.27	$ 644,634.27
2.			$	$
3.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,302.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,104,166.71	$ 648,936.27

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.

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

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 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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Resident Care		2019	$ 1,460,000	1
2	CF St. Louis Alloc.			6085	2
3	TOTALS			$ 1,466,085	3

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214		2019		$ 8,410,682	$ -	40	$ 210,267	$ 210,267	$ 280,356	4
5						-		-			5
6						-		-			6
7						-		-			7
8	Allocated from CF St Louis		2016		32,767	-	35	936	936	4,681	8
	Improvement Type**										
9						-		-			9
10	Repaired 10 exhaust fans on roof, leak, patching near windows			2019	5,375	269	20	269		336	10
11	Flooring basement corridor, gym, 1st floor entry lobby			2019	41,802	2,090	20	2,090		2,264	11
12	Remodel hallways, front entrance, paint, wallpaper, install new lights			2019	122,100	6,105	20	6,105		6,105	12
13	Custom Cabinet sign and Mounting Pole			2020	21,145	529	20	529		529	13
14	Installation of Electric Boxes, 12GA Wire, Outlet and TV Cable			2020	3,100	78	20	78		78	14
15	lines										15
16	Removal and re-roofing of the mansard roofs - throughout the			2020	38,000	950	20	950		950	16
17	building										17
18	Install New Boiler, Pump and all necessary 2" copper piping, flue			2020	15,700	393	20	393		393	18
19	pipe with Barometric Vent - Kitchen					-		-			19
20						-		-			20
21						-		-			21
22	To reconcile book depreciation					16,176		-	(16,176)		22
23						-		-			23
24						-		-			24
25						-		-			25
26	Allocated from Legacy HC Financial Services			2018	244	-	20	12	12	36	26
27	Allocated from Legacy HC Financial Services			2020	183	-	20	9	9	9	27
28						-		-			28
29	Allocated from CF St Louis			2016	203,438	-	20	10,172	10,172	50,860	29
30	Allocated from CF St Louis			2017	4,722	-	20	236	236	944	30
31	Allocated from CF St Louis			2019	42,798	-	20	2,140	2,140	4,280	31
32	Allocated from CF St Louis			2020	2,251	-	20	113	113	113	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 Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,116,566	$ 4,136	$ 223,313	$ 219,177	5	$ 295,116	71
72	Current Year Purchases	62,921	6,092	6,092		5-7	6,092	72
73	Fully Depreciated Assets							73
74	See SCH 13A	13,894		1,390	1,390	10	7,036	74
75	TOTALS	$ 1,193,381	$ 10,228	$ 230,795	$ 220,567		$ 308,244	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	N/A			$	$ -	$ -	$		$	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)	$ 11,603,773	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,817	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 465,093	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 428,276	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 660,177	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: Bella Terra Streamwood
IDPH License ID Number: 0055954
Fiscal Year End: 12/31/2020

Schedule 13A

XI. Ownership Costs
Line 74 - Equipment

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocated from Legacy HC Fin Svc	$ 9,815	$	$ 982	$ 982	10	$ 5,015
Allocated from CF St. Louis	4,079		408	408	10	2,021
TOTALS	$ 13,894	$ 0	$ 1,390	$ 1,390		$ 7,036

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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:	N/A			$			3
4	Additions							4
5								5
6	Allocated from Mgmt Co				39,650			6
7	TOTAL				$ 39,650 **			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 ☒ X 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: $ 52,713 Description: See Schedule 14A
(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 Mgmt Co		$	$ 5,145	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,145	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: **Bella Terra Streamwood**
IDPH License ID Number: **0055954**
Fiscal Year End: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Durable Medical Equipment Rental	35,786
Oxygen Equipment Rental	6,976
Housekeeping Equipment Rental	2,860
Office Equipment Rental	6,563
Allocated from Mgmt Co	528
Total - Line 16	**52,713**

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

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

It is the policy of this facility to only hire certified nurses aides.

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	5,905	$ 425,182	$	5,905	$ 425,182	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,035	146,554		2,035	146,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,123	440,884		6,123	440,884	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				339,493		339,493	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					10,947		10,947	12
13	Other (specify): Dialysis	39(3)			1,624	116,963		1,624	116,963	13
14	TOTAL			$	15,687	$ 1,129,583	$ 350,440	15,687	$ 1,480,023	14

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

STATE OF ILLINOIS

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 46,363	$ 46,363	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 255,025)	2,823,482	2,825,341	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	9,847	9,847	6
7	Other Prepaid Expenses	290,545	144,682	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): Refund	669	669	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,170,906	$ 3,026,902	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	1,466,085	13
14	Buildings, at Historical Cost	-	-	14
15	Leasehold Improvements, at Historical Cost	247,221	8,944,307	15
16	Equipment, at Historical Cost	164,487	1,193,381	16
17	Accumulated Depreciation (book methods)	(41,194)	(660,177)	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 Sch 17A	464,592	564,592	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 835,106	$ 11,508,187	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,006,012	$ 14,535,089	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,057	$ 250,057	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	257,455	257,455	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,610	6,610	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	676,864	32
33	Accrued Interest Payable	-	-	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,279,725	10,753,197	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,793,847	$ 11,944,183	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,334,017	1,334,017	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43		-	-	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,334,017	$ 1,334,017	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,127,864	$ 13,278,200	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 878,148	$ 1,256,889	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,006,012	$ 14,535,089	48

***(See instructions.)**

Facility Name: **Bella Terra Streamwood**
IDPH License ID Number: **0055954**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Goodwill	-	799,318
Accumulated Amortization - Goodwill	-	(699,318)
Accrued Rent	272,526	272,526
Deferred Rent	145,863	145,863
Loan - Lifescan	36,598	36,598
Bad Debt Part A - Mmai	7,623	7,623
Resident Fund	1,982	1,982
Total - Line 23	**464,592**	**564,592**
	-	-

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due To/From - Ccg Kalambo Falls Invest	-	9,466,967
Due To/From Propco	652,309	652,309
Deferred Soc Sec Tax	259,784	259,784
Accrued Monthly Assessment Fee	66,910	66,910
Prepaid Insurance - Workmans Comp	66,753	66,753
Accrued Expense	73,633	73,633
Due To/From - Bella Terra Streamwood & Management	46,849	46,849
Insurance Refund Exchange	27,925	27,925
Accrued Bcbs Ee Insurance	24,895	31,400
Due To/From Medicare	44,691	44,691
Due To/From Prior Owner	12,801	12,801
Accrued Accounting Fees	5,780	5,780
Exchange	(2,177)	(2,177)
Accrued Management Fees Entities	(428)	(428)
Total - Line 36	**1,279,725**	**10,753,197**
	-	-

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (21,840)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (21,840)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	899,988	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)**	$ 899,988	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)**	$ 878,148	24 *

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,471,208	1
2	Discounts and Allowances for all Levels	(8,393,726)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,077,482	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	4,006,125	6
7	Oxygen	438	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,006,563	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,572,614	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	289,858	17
18	Sale of Supplies to Non-Patients	52,146	18
19	Laboratory	35,602	19
20	Radiology and X-Ray	(55)	20
21	Other Medical Services	7,952	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,958,117	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	5,202	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,202	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	8,976	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,976	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,056,340	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,926,636	31
32	Health Care	5,039,747	32
33	General Administration	2,971,999	33
	B. Capital Expense		
34	Ownership	1,903,558	34
	C. Ancillary Expense		
35	Special Cost Centers	1,929,804	35
36	Provider Participation Fee	384,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,156,352	40
41	**Income before Income Taxes (line 30 minus line 40)****	899,988	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 899,988	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,986,775	44
45	Private Pay - Net Inpatient Revenue	284,728	45
46	Medicare - Net Inpatient Revenue	1,310,880	46
47	Other-(specify) Insurance	547,510	47
48	Other-(specify) Part B	(1,052,411)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,077,482	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^Entity is a cash basis taxpayer.

Facility Name: **Bella Terra Streamwood**
IDPH License ID Number: **0055954**
Fiscal Year End: **12/31/2020**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Laboratory - Prior Period	7,805
Misc Income	(3,157)
Rentals	1,948
Rebates	1,240
Telehealth Services	964
Rentals - Prior Period	143
Discounts Earned	33
Total - Line 28	**8,976**

-

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,973	2,133	$ 142,960	$ 67.02	1
2	Assistant Director of Nursing	1,998	2,259	106,280	47.05	2
3	Registered Nurses	33,887	36,302	1,356,946	37.38	3
4	Licensed Practical Nurses	25,340	27,791	853,186	30.70	4
5	CNAs & Orderlies	88,264	94,375	1,730,144	18.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,766	1,870	49,878	26.68	8
9	Activity Director					9
10	Activity Assistants	9,182	9,622	138,385	14.38	10
11	Social Service Workers	5,781	6,180	146,536	23.71	11
12	Dietician					12
13	Food Service Supervisor	1,870	1,894	45,193	23.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,166	24,128	380,448	15.77	15
16	Dishwashers					16
17	Maintenance Workers	1,933	2,052	70,115	34.18	17
18	Housekeepers	21,401	23,041	321,321	13.95	18
19	Laundry	4,544	4,983	68,164	13.68	19
20	Administrator	1,978	2,239	138,879	62.03	20
21	Assistant Administrator	1,192	1,293	40,549	31.36	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,494	20,871	401,915	19.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Alzheimer Supervi	3,745	3,887	155,598	40.03	32
33	Other(specify) Admissions Coord	1,646	1,832	47,679	26.02	33
34	TOTAL (lines 1 - 33)	249,160	266,751	$ 6,194,178 *	$ 23.22	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	$ 2,400	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	18,376	10(7)	38
39	Pharmacist Consultant	Monthly	6,062	10(3)	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	2,901	11(3)	44
45	Social Service Consultant	Monthly	5,292	12(7)	45
46	Other(specify)				46
47	MDS Consultant	Monthly	47,275	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 106,306		49

C. CONTRACT NURSES

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

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gutnicki, Ariel	Administrator/Asst Admin	0.00%	$ 45,156
Provido, Christina	Asst Administrator	0.00%	14,318
Streit, Erika	Administrator	0.00%	39,355
Dauber, Jonathan	Administrator	0.00%	80,599
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 179,428

B. Administrative - Other

Description	Amount
Management Fees	$ 681,603
(Eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 681,603
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 24,000
Cortex Health Inc	Other Professional fees	10,216
Patient Ping	Other Professional fees	9,700
Achieve Accreditation LLC	Joint Commission Consultant	7,770
Telemedicine Solutions	Other Professional fees	7,408
Stout Risius Ross	Other Professional fees	5,526
Ravi Fernando	Other Professional fees	2,600
Compliagent	Other Professional fees	2,043
Personnel Planners	Unemployment Tax Consultant	1,695
Hygieneering, Inc.	Other Professional fees	1,206
Apploi Corp	Other Professional fees	468
See Sch 21C	Various	151,211
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 223,843

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,826
Unemployment Compensation Insurance	91,556
FICA Taxes	438,799
Employee Health Insurance	192,872
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	3,100
Other Employee Benefits	13,372
TOTAL (agree to Schedule V, line 22, col.8)	$ 828,525

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,686
Advertising: Employee Recruitment	328
Health Care Worker Background Check	
(Indicate # of checks performed 119)	1,194
Patient Background Checks 408	4,080
Miscellaneous Licenses & Fees	5,899
Miscellaneous Dues & Subscriptions	19,158
Health Care Council of Illinois	38,092
Illinois Health Care Association	18,156
Allocated from Mgmt Co	4,379
Less: Public Relations Expense	(24,035)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,937

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,979
Allocated from Mgmt Co	174
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,153

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Bella Terra Streamwood**
IDPH License ID Number: **0055954**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Total of professional service from 21C	Various	72,632
Lighthouse Services, Inc	Other Professional fees	159
AR Proactive Workflows	Other Professional fees	122
Telemedicine Solutions Llc: Legacy Healthcare	Other Professional fees	700
Paycor	Payroll services	34,911
Mayer Brown LLP	Legal expenses	56,378
Skidelsky & Associates	Legal expenses	50,400
Meyer Magence	Legal expenses	3,375
Erika Streit	Legal expenses	2,778
Stone Pogrund & Korey LLC	Legal expenses	1,274
Polsinelli PC	Legal expenses	529
Nelson Hardiman LLP	Legal expenses	233
Corporation Service Company	Legal expenses	149
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC	Legal expenses	126
Sb2 Inc	Legal expenses	77
	Total (agree to Schedule V, line 19, column 3)	223,843
Allocated from Management Company	Professional Services	34,268
Less: Non-Allowable Legal Fees		(290)
	Total (agree to Schedule V, line 19, column 8)	257,821

Facility Name & ID Number Bella Terra Streamwood # 0055954 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $18,156 & HCCI - $38,092**

(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? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,906** Line **10(2)**

(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. $ **384,608**
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? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** 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 1**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
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? **Yes**
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.