FOR BHF USE

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

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

I. IDPH License ID Number: 0055962

Facility Name: Bella Terra Wheeling

Address: 730 West Hintz Road (Number) Wheeling (City) 60090 (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	

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

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 Wheeling # 0055962 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	215	Skilled (SNF)	215	78,690	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	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	45,124	5,553	8,517	59,194	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,124	5,553	8,517	59,194	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.22%

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 215 and days of care provided 6,778

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 Wheeling # 0055962 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	500,054	93,537	23,985	617,576		617,576	3,570	621,146			1
2	Food Purchase		426,868		426,868		426,868	7,721	434,589			2
3	Housekeeping	489,912	39,326	134	529,372		529,372	2,632	532,004			3
4	Laundry	143,339	24,490	-	167,829		167,829	179	168,008			4
5	Heat and Other Utilities			198,397	198,397		198,397	1,372	199,769			5
6	Maintenance	42,589	93,929	216,897	353,415		353,415	20,406	373,821			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	1,175,894	678,150	439,413	2,293,457		2,293,457	35,880	2,329,337			8
	B. Health Care and Programs											
9	Medical Director	-	-	34,250	34,250		34,250		34,250			9
10	Nursing and Medical Records	5,472,204	232,748	68,517	5,773,469		5,773,469	134,945	5,908,414			10
10a	Therapy	178,881	-	-	178,881		178,881		178,881			10a
11	Activities	181,518	12,956	1,989	196,463		196,463	10	196,473			11
12	Social Services	156,854	-	1,072	157,926		157,926	7,050	164,976			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	8,600	8,600		8,600		8,600			14
15	Other (specify):* **Alloc. Mgmt. Bene**	-	-	-				7,312	7,312			15
16	**TOTAL Health Care and Programs**	5,989,457	245,704	114,428	6,349,589		6,349,589	149,317	6,498,906			16
	C. General Administration											
17	Administrative	155,399	-	810,759	966,158		966,158	(732,287)	233,871			17
18	Directors Fees			-								18
19	Professional Services			159,849	159,849		159,849	32,411	192,260			19
20	Dues, Fees, Subscriptions & Promotions			72,116	72,116		72,116	(19,803)	52,313			20
21	Clerical & General Office Expenses	479,513	-	255,862	735,375		735,375	339,849	1,075,224			21
22	Employee Benefits & Payroll Taxes			1,106,615	1,106,615		1,106,615		1,106,615			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			3,919	3,919		3,919	175	4,094			24
25	Other Admin. Staff Transportation		-	618	618		618	5,866	6,484			25
26	Insurance-Prop.Liab.Malpractice			308,873	308,873		308,873	500	309,373			26
27	Other (specify):* **Alloc. Mgmt. Bene**			-				31,452	31,452			27
28	**TOTAL General Administration**	634,912		2,718,611	3,353,523		3,353,523	(341,837)	3,011,686			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,800,263	923,854	3,272,452	11,996,569		11,996,569	(156,640)	11,839,929			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 Wheeling #0055962 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,530	30,530		30,530	284,744	315,274			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			73,096	73,096		73,096	(16,891)	56,205			32
33	Real Estate Taxes			666,832	666,832		666,832	114,866	781,698			33
34	Rent-Facility & Grounds			986,125	986,125		986,125	(946,290)	39,835			34
35	Rent-Equipment & Vehicles			105,411	105,411		105,411	5,699	111,110			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			1,861,994	1,861,994		1,861,994	(557,872)	1,304,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	386,083	839,764	1,225,847		1,225,847		1,225,847			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			454,806	454,806		454,806		454,806			42
43	Other (specify):* Non-Allowable Cos	140,669	-	498,343	639,012		639,012	(639,012)				43
44	**TOTAL Special Cost Centers**	140,669	386,083	1,792,913	2,319,665		2,319,665	(639,012)	1,680,653			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,940,932	1,309,937	6,927,359	16,178,228		16,178,228	(1,353,524)	14,824,704			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 Wheeling # 0055962 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(20,294)	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	289	30		9
10	Interest and Other Investment Income	(21,648)	32		10
11	Discounts, Allowances, Rebates & Refunds	(489)	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)	(1,440)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,113)	43		18
19	Entertainment	(8,629)	43		19
20	Contributions	(2,590)	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	(359,235)	43		24
25	Fund Raising, Advertising and Promotional	(20,604)	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	(485,342)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (933,095)		$	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)	(420,429)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (420,429)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,353,524)		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

STATE OF ILLINOIS

Bella Terra Wheeling

ID# 0055962

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (31,190)	43	1
2	X-Rays - Part A	(19,331)	43	2
3	Sequestration expenses	(20,608)	43	3
4	Consolidated Billing charges	(1,453)	43	4
5	Admissions directors salary	(90,391)	43	5
6	Guest service directors salary	(50,278)	43	6
7	Swag Store	144	43	7
8	Disallow lobbying expenses	(24,202)	20	8
9	Nonallowable Legal fees	(290)	19	9
10	Misc Income	(249)	21	10
11	Amortization Goodwill	(230,287)	36	11
12	Adj buiding rent expense	(17,207)	34	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**	(485,342)		49

Facility Name & ID Number Bella Terra Wheeling # 0055962 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-Supplement		

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	$ 986,125	Wheeling Property Holdings, LLC	100%	$ 17,207	$ (968,918)	1
2	V	33	Property Taxes	666,832	Wheeling Property Holdings, LLC	100%	777,376	110,544	2
3	V	21	Filing Fees		Wheeling Property Holdings, LLC	100%	75	75	3
4	V	19	Professional Fees - Accounting		Wheeling Property Holdings, LLC	100%	16,050	16,050	4
5	V	30	Depreciation		Wheeling Property Holdings, LLC	100%	269,378	269,378	5
6	V	36	Amortization Goodwill		Wheeling Property Holdings, LLC	100%	230,287	230,287	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,652,957			$ 1,310,373	$ * (342,584)	14

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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%	$ 4,037	$ 4,037	15
16	V	1	Dietary Supplies		Legacy Healthcare Financial Services	100%	22	22	16
17	V	2	Food		Legacy Healthcare Financial Services	100%	7,721	7,721	17
18	V	3	Housekeeping		Legacy Healthcare Financial Services	100%	2,632	2,632	18
19	V	4	Linen Replacement		Legacy Healthcare Financial Services	100%	179	179	19
20	V	6	Maintenance Salary		Legacy Healthcare Financial Services	100%	12,453	12,453	20
21	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services	100%	739	739	21
22	V	10	Nursing Salary		Legacy Healthcare Financial Services	100%	103,073	103,073	22
23	V	10	Nurse/Medical Director Consultant		Legacy Healthcare Financial Services	100%	9,728	9,728	23
24	V	10	Medical Supplies		Legacy Healthcare Financial Services	100%	22,144	22,144	24
25	V	12	Social Service Salary		Legacy Healthcare Financial Services	100%	7,022	7,022	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	810,759	Legacy Healthcare Financial Services	100%	24,691	(786,068)	28
29	V	17	Administrative (Non-Owner)		Legacy Healthcare Financial Services	100%	53,781	53,781	29
30	V	19	Propay Fees		Legacy Healthcare Financial Services	100%	960	960	30
31	V	19	Accounting Fees		Legacy Healthcare Financial Services	100%	1,093	1,093	31
32	V	19	Legal / Other Professional Fees		Legacy Healthcare Financial Services	100%	23,708	23,708	32
33	V	20	License / Dues / Permits		Legacy Healthcare Financial Services	100%	4,398	4,398	33
34	V	21	A&G Wages		Legacy Healthcare Financial Services	100%	316,616	316,616	34
35	V	21	Office Expenses		Legacy Healthcare Financial Services	100%	23,088	23,088	35
36	V	24	Education & Seminars		Legacy Healthcare Financial Services	100%	175	175	36
37	V	25	Travel		Legacy Healthcare Financial Services	100%	5,866	5,866	37
38	V	26	Insurance - General		Legacy Healthcare Financial Services	100%	155	155	38
39	Total			$ 810,759			$ 624,319	$ * (186,440)	39

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Non-Nursing Payroll Taxes / Benefits	$	Legacy Healthcare Financial Services	100%	$ 31,452	$ 31,452	15
16	V	34	Rent Expense		Legacy Healthcare Financial Services	100%	39,713	39,713	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%	530	530	18
19	V	35	Auto Rental		Legacy Healthcare Financial Services	100%	5,169	5,169	19
20	V	15	Nursing Payroll Taxes / Benefits		Legacy Healthcare Financial Services	100%	7,312	7,312	20
21	V	30	Depreciation Expense		Legacy Healthcare Financial Services	100%	1,007	1,007	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			$			$ 85,305	$ * 85,305	39

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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%	$ 1,372	$ 1,372	15
16	V	6	REPAIRS & MAINTENANCE		CF ST. LOUIS, LLC	100%	1,330	1,330	16
17	V	19	PROPERTY VALUATION FEES		CF ST. LOUIS, LLC	100%	470	470	17
18	V	19	PROFESSIONAL FEES		CF ST. LOUIS, LLC	100%	107	107	18
19	V	20	DUES & SUBSCRIPTIONS		CF ST. LOUIS, LLC	100%	1	1	19
20	V	21	OFFICE EXPENSE		CF ST. LOUIS, LLC	100%	319	319	20
21	V	26	INSURANCE		CF ST. LOUIS, LLC	100%	345	345	21
22	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	8,465	8,465	22
23	V	32	INTEREST EXPENSE		CF ST. LOUIS, LLC	100%	4,757	4,757	23
24	V	33	REAL ESTATE TAXES		CF ST. LOUIS, LLC	100%	4,322	4,322	24
25	V	30	DEPRECIATION		CF ST. LOUIS, LLC	100%	5,605	5,605	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			$			$ 27,093	$ * 27,093	39

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs and Maintenance	$ 13,500	ReMed Services, LLC		$ 19,384	$ 5,884	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			$ 19,384	$ * 5,884	39

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 42,281	ProPay HR LLC		$ 32,594	$ (9,687)	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			$ 42,281			$ 32,594	$ * (9,687)	39

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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	Wheeling Property Ho	Wheeling	Real Estate	30

Facility Name & ID Number Bella Terra Wheeling # 0055962 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 Wheeling # 0055962 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	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Wheeling # 0055962 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		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										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 Wheeling # 0055962 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	78,690	$ 4,037	1
2	1	Dietary Supplies	AVAIL. BED DAYS	2,540,133	53	697		78,690	22	2
3	2	Food	AVAIL. BED DAYS	2,540,133	53	249,220		78,690	7,721	3
4	3	Housekeeping	AVAIL. BED DAYS	2,540,133	53	84,952		78,690	2,632	4
5	4	Linen Replacement	AVAIL. BED DAYS	2,540,133	53	5,771		78,690	179	5
6	6	Maintenance Salary	AVAIL. BED DAYS	2,540,133	53	401,986	401,986	78,690	12,453	6
7	6	Repairs & Maintenance	AVAIL. BED DAYS	2,540,133	53	23,857		78,690	739	7
8	10	Nursing Salary	AVAIL. BED DAYS	2,540,133	53	3,327,223	3,327,223	78,690	103,073	8
9	10	Nurse/Medical Director Consultan	AVAIL. BED DAYS	2,540,133	53	314,035		78,690	9,728	9
10	10	Medical Supplies	AVAIL. BED DAYS	2,540,133	53	714,824		78,690	22,144	10
11	12	Social Service Salary	AVAIL. BED DAYS	2,540,133	53	226,662	226,662	78,690	7,022	11
12	11	Activities Program	AVAIL. BED DAYS	2,540,133	53	335		78,690	10	12
13	12	Social Service Consultant	AVAIL. BED DAYS	2,540,133	53	893		78,690	28	13
14	17	COO / Administrative Salary	AVAIL. BED DAYS	2,540,133	53	797,017	797,017	78,690	24,691	14
15	17	Administrative (Non-Owner)	AVAIL. BED DAYS	2,540,133	53	1,736,060		78,690	53,781	15
16	19	Propay Fees	AVAIL. BED DAYS	2,540,133	53	31,002		78,690	960	16
17	19	Accounting Fees	AVAIL. BED DAYS	2,540,133	53	35,278		78,690	1,093	17
18	19	Legal / Other Professional Fees	AVAIL. BED DAYS	2,540,133	53	765,313		78,690	23,708	18
19	20	License / Dues / Permits	AVAIL. BED DAYS	2,540,133	53	141,983		78,690	4,398	19
20	21	A&G Wages	AVAIL. BED DAYS	2,540,133	53	10,220,453	10,220,453	78,690	316,616	20
21	21	Office Expenses	AVAIL. BED DAYS	2,540,133	53	745,293		78,690	23,088	21
22	24	Education & Seminars	AVAIL. BED DAYS	2,540,133	53	5,655		78,690	175	22
23	25	Travel	AVAIL. BED DAYS	2,540,133	53	189,364		78,690	5,866	23
24	26	Insurance - General	AVAIL. BED DAYS	2,540,133	53	4,997		78,690	155	24
25	TOTALS					$ 20,153,173	$ 15,103,644		$ 624,319	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 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	$	78,690	$ 31,452	1
2	34	Rent Expense	AVAIL. BED DAYS	2,540,133	53	1,281,940		78,690	39,713	2
3	34	Offsite Storage / Parking	AVAIL. BED DAYS	2,540,133	53	3,949		78,690	122	3
4	35	Equipment Rental	AVAIL. BED DAYS	2,540,133	53	17,109		78,690	530	4
5	35	Auto Rental	AVAIL. BED DAYS	2,540,133	53	166,843		78,690	5,169	5
6	15	Nursing Payroll Taxes / Benefits	AVAIL. BED DAYS	2,540,133	53	236,021		78,690	7,312	6
7	30	Depreciation Expense	Direct Allocation						1,007	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	$		$ 85,305	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 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	$	78,690	$ 1,372	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	2,540,133	34	42,932		78,690	1,330	2
3	19	PROPERTY VALUATION FEES	AVAIL. BED DAYS	2,540,133	34	15,181		78,690	470	3
4	19	PROFESSIONAL FEES	AVAIL. BED DAYS	2,540,133	34	3,453		78,690	107	4
5	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	2,540,133	34	23		78,690	1	5
6	21	OFFICE EXPENSE	AVAIL. BED DAYS	2,540,133	34	10,298		78,690	319	6
7	26	INSURANCE	AVAIL. BED DAYS	2,540,133	34	11,124		78,690	345	7
8	30	DEPRECIATION	AVAIL. BED DAYS	2,540,133	34	273,261		78,690	8,465	8
9	32	INTEREST EXPENSE	AVAIL. BED DAYS	2,540,133	34	153,558		78,690	4,757	9
10	33	REAL ESTATE TAXES	AVAIL. BED DAYS	2,540,133	34	139,524		78,690	4,322	10
11	30	DEPRECIATION	DIRECT						5,605	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	$		$ 27,093	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 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			$	$		$ 19,384	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					$	$		$ 19,384	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 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			$	$		$ 32,594	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					$	$		$ 32,594	25

Facility Name & ID Number: Bella Terra Wheeling # 0055962 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	$ 1,923,367	$ 739,646	9/1/2020	0.0535	$ 73,096	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National Government Services		X	Medicare AAP		4/30/2020	31,710	31,710	4/30/2022		-	6
7												7
8												8
9	TOTAL Facility Related						$ 1,955,077	$ 771,356			$ 73,096	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(21,648)	12
13								Allocated from Mgmt Co.			4,757	13
14	TOTAL Non-Facility Related						$	$			$ (16,891)	14
15	TOTALS (line 9+line14)						$ 1,955,077	$ 771,356			$ 56,205	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 Wheeling # 0055962 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

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

Line			Amount	
1. Real Estate Tax accrual used on 2019 report.		$	632,353	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	$	687,673	2
3. Under or (over) accrual (line 2 minus line 1).		$	55,320	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	722,056	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.		4,322	
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.		$	781,698	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019	687,673	12

Beginning Accrual Adjusted

Allocated from CF St. Louis LLC: 4322

	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 Wheeling COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0055962

CONTACT PERSON REGARDING THIS REPORT Moti Ninio

TELEPHONE (847) 676-5315 FAX #: (847) 676-5315

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.	03-10-401-027-0000	Nursing Home	$ 687,672.82	$ 687,672.82
2.			$	$
3.	10-23-406-034-0000	Home Office Allocation	$ 459,532.44	$ 4,322.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,147,205.26	$ 691,994.82

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 Wheeling # 0055962 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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).

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	-	2019	$ 1,670,000	1
2	Allocated from Mgmt. Co.		2016	6114	2
3	TOTALS			$ 1,676,114	3

Facility Name & ID Number Bella Terra Wheeling # 0055962 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					$	$ -		$ -	$	$	4
5	215		2015		5,151,140	-		128,779	128,779	171,705	5
6	Allocated CF St. Louis LLC		2016		32,920	-		941	941	4,703	6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Remodel hallway-lighting, front entrance, conference room carpet, wallpa					-		-			9
10	paint basement, counter top in lunch room, flooring therapy room			2019	127,200	6,360	20	6,360		7,420	10
11	Repaired 20 exhaust fans on roof, 4 cracks, patched leak from laundry roo			2019	2,725	136	20	136		159	11
12	Flooring, vinyl plank carpet, basement corridor, thearpy room, lobby			2019	44,200	2,210	20	2,210		2,578	12
13	Water heater boiler repair-ball valves, fix water line leak			2019	2,550	128	20	128		139	13
14											14
15	Mill & Pave and Seal Coating & Re Striping			2020	13,240	331	20	331		331	15
16	Installation of 16 new Cameras with 4 monitor's, BNC Connector, HDMI			2020	9,010	644	7	644		644	16
17	Sidewalk & Patio			2020	6,650	166	20	166		166	17
18	Crabapple & White Pine Tree Installation			2020	5,730	287	10	287		287	18
19	Removal and re-roofing of the mansard roof			2020	23,275	582	20	582		582	19
20	Supply and install 1" fiber glass pipe insulation with self seal lap, Supply a			2020	6,316	158	20	158		158	20
21						-		-			21
22	To reconcile book depreciation					10,223		-	(10,223)		22
23						-		-			23
24						-		-			24
25						-		-			25
26	Allocated from Legacy			2018	244	-	20	12	12	37	26
27	Allocated from Legacy			2020	184	-	20	9	9	9	27
28						-		-			28
29	Allocated from CF St. Louis LLC			2016	204,389	-	20	10,219	10,219	51,097	29
30	Allocated from CF St. Louis LLC			2017	4,744	-	20	237	237	949	30
31	Allocated from CF St. Louis LLC			2019	42,998	-	20	2,150	2,150	4,300	31
32	Allocated from CF St. Louis LLC			2020	2,261	-	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 Wheeling # 0055962 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	$ 774,342	$ 3,757	$ 154,868	$ 151,111	5	$ 205,492	71
72	Current Year Purchases	52,612	5,548	5,548		5	5,548	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt.	13,959		1,396	1,396		7,070	74
75	TOTALS	$ 840,913	$ 9,305	$ 161,812	$ 152,507		$ 218,110	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)	$ 8,196,803	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,530	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,274	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 284,744	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 463,487	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	Construction in Progress	$ 9,500	92
93			93
94			94
95		$ 9,500	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 Wheeling
IDPH License ID Number: 0055962
Fiscal Year End: 12/31/2020

Schedule 13A

XI. Ownership Costs
Line 74 -Equipment

Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6
Allocated from Legacy HC Fin Svc	$ 9,861	$	$ 986	$ 986	10	$ 5,038
Allocated from CF St. Louis	4,098		410	410	10	2,032
				0		
TOTALS	$ 13,959	$ 0	$ 1,396	$ 1,396		$ 7,070

Facility Name & ID Number: Bella Terra Wheeling # 0055962 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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Alloc fr Mgmt Co				39,835			6
7	TOTAL				$ 39,835 **			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: $ 105,941 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			$	$	17
18					18
19					19
20	Alloc fr Mgmt			5,169	20
21	TOTAL		$	$ 5,169	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 Wheeling**
IDPH License ID Number: **0055962**
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	86,678
Oxygen Equipment Rental	5,972
Housekeeping Equipment Rental	5,005
Office Equipment Rental	7,756
Allocated from management co.	530
Total - Line 16	**105,941**

Facility Name & ID Number Bella Terra Wheeling # 0055962 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,113	$ 296,123	$	4,113	$ 296,123	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,509	108,629		1,509	108,629	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		6,042	435,012		6,042	435,012	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				368,954		368,954	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					17,129		17,129	12
13	Other (specify):									13
14	TOTAL			$	11,664	$ 839,764	$ 386,083	11,664	$ 1,225,847	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 Wheeling # 0055962 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	$ 259,310	$ 259,310	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 470,076)	3,171,951	3,173,583	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	8,636	8,636	6
7	Other Prepaid Expenses	345,995	345,995	7
8	Accounts Receivable (owners or related parties)	2,730	2,730	8
9	Other(specify): See Sch 17A	16,948	16,948	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,805,570	$ 3,807,202	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	5,730	1,676,114	13
14	Buildings, at Historical Cost	-	32,920	14
15	Leasehold Improvements, at Historical Cost	235,166	5,646,856	15
16	Equipment, at Historical Cost	123,954	840,913	16
17	Accumulated Depreciation (book methods)	(35,749)	(463,487)	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 (spe CIP	9,500	9,500	22
23	Other(specify): See Sch 17A	507,026	607,026	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 845,627	$ 8,349,842	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,651,197	$ 12,157,044	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 264,095	$ 264,095	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	459,268	459,268	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,148	18,148	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	722,056	32
33	Accrued Interest Payable	2,810	2,810	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,053,514	7,488,436	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,797,835	$ 8,954,813	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	771,356	771,356	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)**	$ 771,356	$ 771,356	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,569,191	$ 9,726,169	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,082,006	$ 2,430,875	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,651,197	$ 12,157,044	48

*(See instructions.)

Facility Name: **Bella Terra Wheeling**
IDPH License ID Number: **0055962**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Refund	16,144	16,144
Insurance Refund Exchange	(950)	(950)
Security Deposit	1,754	1,754
Total - Line 9	**16,948**	**16,948**
	-	-

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

Description	Operating	After Consolidation
Resident Fund	1,058	1,058
Refund - Transfer	3,800	3,800
Loan - Lifescan	43,270	43,270
Accrued Rent	196,848	196,848
Due To/From Medicare	118,560	118,560
Bad Debt Part A - Mmai	2,959	2,959
Deferred Rent	140,531	140,531
Goodwill	-	790,860
A/A Goodwill	-	(690,860)
Total - Line 23	**507,026**	**607,026**
	-	-

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

Description	Operating	After Consolidation
Exchange	16,125	16,125
Prepaid Insurance - Workmar	116,499	116,499
Due To/From - Bella Terra W	117,515	117,515
Due To/From Propco	222,277	222,277
Due To/From Prior Owner	52,225	52,225
Accrued Expense	66,139	66,139
Accrued Accounting Fees	5,780	5,780
Accrued Monthly Assessmen	92,804	92,804
Accrued Management Fees E	(8,703)	(8,703)
Accrued Bcbs Ee Insurance	24,943	47,885
Deferred Soc Sec Tax	347,910	347,910
Prepaid Income	-	140,531
Due To/From	-	6,271,449
Total - Line 36	**1,053,514**	**7,488,436**
	-	-

Facility Name & ID Number Bella Terra Wheeling # 0055962 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**	$ 295,722	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 295,722	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,786,284	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,786,284	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,082,006	24 *

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 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	$ 22,282,928	1
2	Discounts and Allowances for all Levels	(9,728,627)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,554,301	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	3,175,750	6
7	Oxygen	280,507	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,456,257	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,435,814	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	323,711	17
18	Sale of Supplies to Non-Patients	34,938	18
19	Laboratory	76,114	19
20	Radiology and X-Ray	(110)	20
21	Other Medical Services	11,228	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,881,695	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	21,648	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,648	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Sch 19A	50,611	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 50,611	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,964,512	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,293,457	31
32	Health Care	6,349,589	32
33	General Administration	3,353,523	33
	B. Capital Expense		
34	Ownership	1,861,994	34
	C. Ancillary Expense		
35	Special Cost Centers	1,864,859	35
36	Provider Participation Fee	454,806	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,178,228	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,786,284	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,786,284	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,024,927	44
45	Private Pay - Net Inpatient Revenue	1,309,987	45
46	Medicare - Net Inpatient Revenue	2,518,699	46
47	Other-(specify) Insurance	326,977	47
48	Other-(specify) Part B	(626,289)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,554,301	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 Wheeling**
IDPH License ID Number: **0055962**
Fiscal Year End: **12/31/2020**

Schedule 19A

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

Description	Amount
Rentals	43,907
Telehealth Services	5,077
Rebates	489
Misc Income	249
Laboratory - Prior Period	889
Total - Line 28	**50,611**
	-

Facility Name & ID Number Bella Terra Wheeling # 0055962 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,044	2,080	$ 124,889	$ 60.04	1
2	Assistant Director of Nursing	2,132	2,277	103,409	45.41	2
3	Registered Nurses	34,977	39,017	1,550,344	39.74	3
4	Licensed Practical Nurses	34,650	38,997	1,170,175	30.01	4
5	CNAs & Orderlies	106,422	118,100	2,307,913	19.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,253	8,215	178,881	21.77	8
9	Activity Director					9
10	Activity Assistants	9,897	10,871	181,518	16.70	10
11	Social Service Workers	5,206	5,745	156,854	27.30	11
12	Dietician					12
13	Food Service Supervisor	1,882	2,080	52,186	25.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,175	30,279	447,868	14.79	15
16	Dishwashers					16
17	Maintenance Workers	1,964	2,081	42,589	20.47	17
18	Housekeepers	30,979	33,913	489,912	14.45	18
19	Laundry	8,902	10,040	143,339	14.28	19
20	Administrator	2,031	2,080	155,399	74.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,760	24,474	479,513	19.59	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	2,442	2,875	59,506	20.70	31
32	Other Health C: Alzheimer Supervi	4,014	4,254	155,968	36.66	32
33	Other(specify) Admissions Coord	3,991	4,220	140,669	33.33	33
34	TOTAL (lines 1 - 33)	309,721	341,599	$ 7,940,932 *	$ 23.25	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 23,985	1(3)	35
36	Medical Director	Monthly	34,250	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	19,690	10(3,7)	38
39	Pharmacist Consultant	Monthly	6,781	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	1,989	11(3)	44
45	Social Service Consultant	Monthly	1,100	12(3,7)	45
46	Other(specify) MDS Consultant	Monthly	47,275	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 135,070		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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 Wheeling # 0055962 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amy Saltzman	Administrator - Regular	0.00%	$ 155,399
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 155,399

B. Administrative - Other

Description	Amount
Management Fees(elminated in column 7)	$ 810,759
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 810,759

C. Professional Services

Vendor/Payee	Type	Amount
Paycor Inc.	Payroll services	$ 42,281
Personnel Planners	Other Professional Fees	915
Compliagent	Other Professional Fees	1,780
Achieve Accreditation LLC	Other Professional Fees	7,767
Cortex Health Inc	Other Professional Fees	8,645
Telemedicine	Other Professional Fees	7,700
PatientPing, Inc.	Other Professional Fees	3,242
Compliagent	Other Professional Fees	1,882
Apploi Corp	Other Professional Fees	467
Hygieneering, Inc.	Other Professional Fees	593
Lighthouse Services, Inc	Other Professional Fees	159
See Sch 21C	Various	84,418
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 159,849

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 143,907
Unemployment Compensation Insurance	99,704
FICA Taxes	581,104
Employee Health Insurance	237,081
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	35,854
Employee Physical Exams	255
Other Employee Benefits	8,710
Allocated fr Mgmt	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,106,615

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,750
Health Care Worker Background Check (Indicate # of checks performed 73)	875
Patient Background Checks 179	2,146
Miscellaneous Licenses & Fees	5,889
Miscellaneous Dues & Subscriptions	1,756
HCCI & IHCA Dues	56,710
Allocated from Mgmt Co.	4,399
Less: Disallow lobbying	(24,202)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,313

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,919
Allocated from management co.	175
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,094

**See instructions.

Facility Name: **Bella Terra Wheeling**
IDPH License ID Number: **0055962**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Balance brought forward from schedule 21C		75,431
Telemedicine	Other Professional Fees	408
Sb2 Inc	Legal Fees	77
Mayer Brown LLP	Legal Fees	252
Stout Risius Ross	Legal Fees	5,526
Stone Pogrund & Korey LLC	Legal Fees	9,509
Skidelsky & Associates	Legal Fees	400
Meyer Magence	Legal Fees	7,162
Baker, Donelson, Bearman, Caldwell & Be	Legal Fees	126
Skidelsky & Associates	Legal Fees	33,770
Corporation Service Company	Legal Fees	149
Polsinelli PC	Legal Fees	529
Stone Pogrund & Kory LLC	Legal Fees	2,510
RSM US LLP	Accounting Fees	24,000
Total (agree to Schedule V, line 19, column 3)		159,849
Allocated from Management Company	Professional Services	32,701
Less: Non-Allowable Legal Fees		(290)
Total (agree to Schedule V, line 19, column 8)		192,260

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 - $18,440 & HCCI - $38,270**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,356** 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. $ **454,806**
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.