

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0053223 Facility Name: Bella Terra Morton Grove Address: 8425 Waukegan Road Morton Grove 60053 County: Cook Telephone Number: (847) 965-8100 Fax #: (847) 965-8104 HFS ID Number: Date of Initial License for Current Owners: 02/13/1969 Type of Ownership: ☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Amanda Springborn Telephone Number: (314) 925-3838

Email Address:

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	643,791	65,628	(500)	708,919		708,919		708,919			1
2	Food Purchase		245,428		245,428		245,428	949	246,377			2
3	Housekeeping	294,665	62,470		357,135		357,135	149	357,284			3
4	Laundry	97,385	15,557	101,695	214,637		214,637		214,637			4
5	Heat and Other Utilities			253,584	253,584		253,584	2,933	256,517			5
6	Maintenance	108,386	13,793	310,350	432,529		432,529	27,314	459,843			6
7	Other (specify):*											7
8	TOTAL General Services	1,144,227	402,876	665,129	2,212,232		2,212,232	31,345	2,243,577			8
	B. Health Care and Programs											
9	Medical Director			95,722	95,722		95,722		95,722			9
10	Nursing and Medical Records	4,006,432	192,891	86,394	4,285,717		4,285,717	91,877	4,377,594			10
10a	Therapy	142,451			142,451		142,451		142,451			10a
11	Activities	214,475	23,814	1,072	239,361		239,361	178	239,539			11
12	Social Services	91,698		6,545	98,243		98,243	1,427	99,670			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Alloc of Benefit							21,313	21,313			15
16	TOTAL Health Care and Programs	4,455,056	216,705	189,733	4,861,494		4,861,494	114,795	4,976,289			16
	C. General Administration											
17	Administrative	203,227		939,379	1,142,606		1,142,606	(917,186)	225,420			17
18	Directors Fees											18
19	Professional Services			174,966	174,966		174,966	39,339	214,305			19
20	Dues, Fees, Subscriptions & Promotions			47,946	47,946		47,946	2,810	50,756			20
21	Clerical & General Office Expenses	561,392		283,376	844,768		844,768	(171,051)	673,717			21
22	Employee Benefits & Payroll Taxes			1,114,976	1,114,976		1,114,976	(60,926)	1,054,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,713	4,713		4,713	2,931	7,644			24
25	Other Admin. Staff Transportation			1,032	1,032		1,032		1,032			25
26	Insurance-Prop.Liab.Malpractice			182,789	182,789		182,789	6,110	188,899			26
27	Other (specify):* Mgmt Alloc of Benefit							95,081	95,081			27
28	TOTAL General Administration	764,619		2,749,177	3,513,796		3,513,796	(1,002,892)	2,510,904			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,363,902	619,581	3,604,039	10,587,522		10,587,522	(856,752)	9,730,770			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			72,195	72,195		72,195	607,151	679,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,555	43,555		43,555	1,040,817	1,084,372			32
33	Real Estate Taxes			648,000	648,000		648,000	2,320	650,320			33
34	Rent-Facility & Grounds			1,321,137	1,321,137		1,321,137	(1,321,087)	50			34
35	Rent-Equipment & Vehicles			32,153	32,153		32,153	79	32,232			35
36	Other (specify):*											36
37	TOTAL Ownership			2,117,040	2,117,040		2,117,040	329,280	2,446,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		332,718	1,184,181	1,516,899		1,516,899		1,516,899			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			401,600	401,600		401,600		401,600			42
43	Other (specify):* Non-Allowable Cos	70,792		578,969	649,761		649,761	(649,761)				43
44	TOTAL Special Cost Centers	70,792	332,718	2,164,750	2,568,260		2,568,260	(649,761)	1,918,499			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,434,694	952,299	7,885,829	15,272,822		15,272,822	(1,177,233)	14,095,589			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,886)	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	(114,442)	30		9
10	Interest and Other Investment Income	(4,263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,716)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(573)	43		18
19	Entertainment	(6,180)	43		19
20	Contributions	(98,467)	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	(228,204)	43		24
25	Fund Raising, Advertising and Promotional	(196,569)	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 Page 5A	(226,286)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (892,586)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(284,647)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (284,647)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,177,233)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Allowable Marketing Salaries	\$ (70,792)	43	1
2	Labs - Part A	(50,762)	43	2
3	Sequestration	(86,458)	43	3
4	Escort Services	(88)	43	4
5	Radiology	(594)	43	5
6	Offset Misc Income	(14,471)	21	6
7	Expense Assets Under \$2500	2,200	6	7
8	Disallow Lobbying Expense	(498)	20	8
9	Patient Personal Items	(4,590)	43	9
10	Non Allowable Legal	(233)	19	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	(226,286)		49

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 PG6 - Supp		See PG6 - Supp		See PG6 - Supp		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	\$	MG Property Holdings	1	\$ 5,744	\$ 5,744	1
2	V	30	Depreciation		MG Property Holdings	1	718,494	718,494	2
3	V	32	Interest		MG Property Holdings	1	1,039,091	1,039,091	3
4	V	34	Rent	1,321,137	MG Property Holdings	1		(1,321,137)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,321,137			\$ 1,763,329	\$ * 442,192	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$	Legacy Healthcare Financial Services, LLC		\$ 208	\$ 208	15
16	V	3	Housekeeping Supplies		Legacy Healthcare Financial Services, LLC		149	149	16
17	V	5	Utilities		Legacy Healthcare Financial Services, LLC		652	652	17
18	V	6	Repairs & Maintenance		Legacy Healthcare Financial Services, LLC		8,649	8,649	18
19	V	17	Administrative Salary - Mgmt Alloc		Legacy Healthcare Financial Services, LLC		13,444	13,444	19
20	V	17	Management Fees	939,379	Legacy Healthcare Financial Services, LLC		0	(939,379)	20
21	V	19	Profesional Fees		Legacy Healthcare Financial Services, LLC		30,559	30,559	21
22	V	20	Dues, Fees, Subscriptions		Legacy Healthcare Financial Services, LLC		2,650	2,650	22
23	V	21	Clerical & General Wages		Legacy Healthcare Financial Services, LLC		203,896	203,896	23
24	V	21	Clerical & General Other	210,000	Legacy Healthcare Financial Services, LLC		31,534	(178,466)	24
25	V	24	Seminars		Legacy Healthcare Financial Services, LLC		1,761	1,761	25
26	V	26	Insurance Expense		Legacy Healthcare Financial Services, LLC		1,519	1,519	26
27	V	27	Employee Benefits - Mgmt Alloc		Legacy Healthcare Financial Services, LLC		50,929	50,929	27
28	V	30	Depreciation Expense		Legacy Healthcare Financial Services, LLC		698	698	28
29	V	32	Interest Expense		Legacy Healthcare Financial Services, LLC		11	11	29
30	V	33	Real Estate Taxes		Legacy Healthcare Financial Services, LLC		1,235	1,235	30
31	V	34	Rent Expense		Legacy Healthcare Financial Services, LLC		65,436	65,436	31
32	V	35	Equipment Rental		Legacy Healthcare Financial Services, LLC		79	79	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,149,379			\$ 413,409	\$ * (735,970)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	Legacy Real Properties, LLC		\$ 89	\$ 89	15
16	V	30	Depreciation		Legacy Real Properties, LLC		2,401	2,401	16
17	V	32	Interest		Legacy Real Properties, LLC		870	870	17
18	V	34	Rent	65,436	Legacy Real Properties, LLC			(65,436)	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			\$ 65,436			\$ 3,360	\$ * (62,076)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	<u>Food</u>	\$	<u>Progressive Healthcare Consulting</u>		\$ 741	\$ 741	15
16	V	6	<u>Repairs & Maintenance - Salary</u>		<u>Progressive Healthcare Consulting</u>		14,309	14,309	16
17	V	6	<u>Repairs & Maintenance - Other</u>		<u>Progressive Healthcare Consulting</u>		509	509	17
18	V	10	<u>Medical & Nursing Supply</u>		<u>Progressive Healthcare Consulting</u>		198	198	18
19	V	10	<u>Nursing Salary</u>	51,389	<u>Progressive Healthcare Consulting</u>		142,362	90,973	19
20	V	12	<u>Activities Program</u>		<u>Progressive Healthcare Consulting</u>		178	178	20
21	V	12	<u>Clergy Salary</u>	1,157	<u>Progressive Healthcare Consulting</u>		2,584	1,427	21
22	V	43	<u>Admissions Salary</u>	34,253	<u>Progressive Healthcare Consulting</u>		145,367	111,114	22
23	V	15	<u>Emp Ben - Nursing</u>		<u>Progressive Healthcare Consulting</u>		21,313	21,313	23
24	V	17	<u>Admin Salary - Non Owner</u>	339,862	<u>Progressive Healthcare Consulting</u>		149,546	(190,316)	24
25	V	19	<u>Professional Fees</u>		<u>Progressive Healthcare Consulting</u>		2,183	2,183	25
26	V	20	<u>Dues, Fees, Subscriptions</u>		<u>Progressive Healthcare Consulting</u>		390	390	26
27	V	21	<u>Clerical & General</u>	20,253	<u>Progressive Healthcare Consulting</u>		2,210	(18,043)	27
28	V	24	<u>Seminars</u>		<u>Progressive Healthcare Consulting</u>		1,170	1,170	28
29	V	27	<u>Emp Ben - Mgmt Alloc</u>		<u>Progressive Healthcare Consulting</u>		44,152	44,152	29
30	V	26	<u>Insurance</u>		<u>Progressive Healthcare Consulting</u>		4,132	4,132	30
31	V	20	<u>Dues, Fees, Subscriptions</u>		<u>Progressive Healthcare Consulting</u>		230	230	31
32	V	22	<u>Employee Benefits</u>	25,154	<u>Progressive Healthcare Consulting</u>			(25,154)	32
33	V	34	<u>Rental</u>		<u>Progressive Healthcare Consulting</u>		50	50	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 472,068			\$ 531,624	\$ * 59,556	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 6,572	ReMED Services, LLC	1	\$ 5,664	\$ (908)	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			\$ 6,572			\$ 5,664	\$ * (908)	39

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

VII. RELATED PARTIES (continued)

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

☒ 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	5	Utilities	\$	CF. St. Louis, Inc.		\$ 2,281	\$ 2,281	15
16	V	6	Repairs & Maintenance		CF. St. Louis, Inc.		2,555	2,555	16
17	V	19	Professional Fees		CF. St. Louis, Inc.		917	917	17
18	V	19	Professional Fees		CF. St. Louis, Inc.		79	79	18
19	V	20	Dues, Fees, Subscriptions		CF. St. Louis, Inc.		4	4	19
20	V	20	Dues, Fees, Subscriptions		CF. St. Louis, Inc.		36	36	20
21	V	21	Clerical & General Other		CF. St. Louis, Inc.		32	32	21
22	V	26	Insurance		CF. St. Louis, Inc.		459	459	22
23	V	32	Interest		CF. St. Louis, Inc.		5,111	5,111	23
24	V	33	Real Estate Taxes		CF. St. Louis, Inc.		1,085	1,085	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 12,559	\$ * 12,559	39

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

Facility Name & ID Number

Bella Terra Morton Grove

0053223

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	Chaim Rajchenbach	40.50	Astoria Place Living & Rehab	Chicago	Legacy Healthcare	Skokie	Management Co.	1
2	Menachem Shabat	40.50	Bella Terra Morton Grove	Morton Grove	Financial Svcs, LLC			2
3	The Rajchenbach 2015 Family Trust	3	Chalet Living & Rehab Center	Chicago				3
4	Ronald Shabat	3	Elmhurst Nursing	Elmhurst	Legacy Real	Skokie	Real Estate	4
5	Yair Zuckerman	10	The Grove of Evanston, LLC	Evanston	Properties, LLC			5
6	Ross Bottner	3	The Villa at Evergreen	Evergreen Park				6
7			The Grove of Fox Valley	Aurora	Grove Healthcare	Skokie	Real Estate	7
8			The Grove of LaGrange Park LLC	LaGrange Park	Properties, LLC			8
9			The Grove at the Lake	Zion				9
10			Lakefront Nursing & Rehab Center, LLC	Chicago	ReMED Services,	Skokie	Medical	10
11			The Grove at Lincoln Park Living & Rehab	Chicago	LLC		Equipment Sales	11
12			Avantara Long-Grove	Long Grove				12
13			The Grove North Living & Rehab Center	Skokie	Progressive	Skokie	Consulting	13
14			The Grove of Northbrook	Northbrook	Healthcare			14
15			Warren Barr North Shore	Highland Park	Consulting			15
16			Avantara Park Ridge	Park Ridge				16
17			Peterson Park Associates Ltd. Partnetship	Chicago	MG Property	Morton Grove	Real Estate	17
18			Warren Barr South Loop	Chicago	Holdings, LLC			18
19			Warren Barr	Chicago				19
20			Aurora Supportive Living	Aurora	Lifeline Ambulance	Chicago	Ambulance Svcs.	20
21								21
22					ProPay	Evanston	Payroll Services	22
23								23
24					ML Group Design	Skokie	Asset Mgmt Fees	24
25								25
26					ML Enterprise	Skokie	Asset Mgmt Fees	26
27								27
28					CF St.Louis Inc	Skokie	Management Co.	28
29								29
30								30

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Yair Zuckerman	Owner	Administrative	10.00	See Att Sch 7A	2.39	4.78	Salary	\$ 9,568	L17, C7	1
2	Ross Bottner	Owner	Administrative	3.00	See Att Sch 7A	1.91	4.78	Salary	9,568	L21, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,136		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Legacy Healthcare Financial Services, LLC
Street Address 3450 Oakton Street
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 679-9797
Fax Number (847) 679-3676

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Bed Days Available	1,629,488	29	\$ 4,354	\$	77,958	\$ 208	1
2	3	Housekeeping Supplies	Bed Days Available	1,629,488	29	3,107		77,958	149	2
3	5	Utilities	Bed Days Available	1,629,488	29	13,622		77,958	652	3
4	6	Repairs & Maintenance	Bed Days Available	1,629,488	29	180,780		77,958	8,649	4
5	17	Administrative Salary - Mgmt Alloc	Bed Days Available	1,629,488	29	281,003	281,003	77,958	13,444	5
6	17	Management Fees	Bed Days Available	1,629,488	29	0		77,958	0	6
7	19	Profesional Fees	Bed Days Available	1,629,488	29	638,758		77,958	30,559	7
8	20	Dues, Fees, Subscriptions	Bed Days Available	1,629,488	29	55,387		77,958	2,650	8
9	21	Clerical & General Wages	Bed Days Available	1,629,488	29	4,261,866	4,261,866	77,958	203,896	9
10	21	Clerical & General Other	Bed Days Available	1,629,488	29	659,124		77,958	31,534	10
11	24	Seminars	Bed Days Available	1,629,488	29	36,800		77,958	1,761	11
12	26	Insurance Expense	Bed Days Available	1,629,488	29	31,752		77,958	1,519	12
13	27	Employee Benefits - Mgmt Alloc	Bed Days Available	1,629,488	29	1,064,526		77,958	50,929	13
14	30	Depreciation Expense	Bed Days Available	1,629,488	29	14,600		77,958	698	14
15	32	Interest Expense	Bed Days Available	1,629,488	29	234		77,958	11	15
16	33	Real Estate Taxes	Bed Days Available	1,629,488	29	25,813		77,958	1,235	16
17	34	Rent Expense	Bed Days Available	1,629,488	29	1,367,746		77,958	65,436	17
18	35	Equipment Rental	Bed Days Available	1,629,488	29	1,654		77,958	79	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 8,641,126	\$ 4,542,869		\$ 413,409	25

Facility Name & ID Number Bella Terra Morton Grove# 0053223

Report Period Beginning:

01/01/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Progressive Healthcare Consulting

Street Address

3450 Oakton Street

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 679-9797

Fax Number

(847) 679-3676

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6				
1	2	Food	Bed Days Available	1,167,679	20	\$ 11,123	\$ 77,745	\$ 741	1	
2	6	Repairs & Maintenance - Salary	Bed Days Available	1,167,679	20	214,912	214,912	77,745	14,309	2
3	6	Repairs & Maintenance - Other	Bed Days Available	1,167,679	20	7,646		77,745	509	3
4	10	Medical & Nursing Supply	Bed Days Available	1,167,679	20	2,971		77,745	198	4
5	10	Nursing Salary	Bed Days Available	1,167,679	20	2,138,189	2,138,189	77,745	142,362	5
6	12	Activities Program	Bed Days Available	1,167,679	20	2,679		77,745	178	6
7	12	Clergy Salary	Bed Days Available	1,167,679	20	38,812	38,812	77,745	2,584	7
8	43	Admissions Salary	Bed Days Available	1,167,679	20	2,183,313	2,183,313	77,745	145,367	8
9	15	Emp Ben - Nursing	Bed Days Available	1,167,679	20	320,111		77,745	21,313	9
10	17	Admin Salary - Non Owner	Bed Days Available	1,167,679	20	2,246,090	2,246,090	77,745	149,546	10
11	19	Professional Fees	Bed Days Available	1,167,679	20	32,795		77,745	2,184	11
12	20	Dues, Fees, Subscriptions	Bed Days Available	1,167,679	20	9,282		77,745	618	12
13	21	Clerical & General	Bed Days Available	1,167,679	20	33,203		77,745	2,211	13
14	24	Seminars	Bed Days Available	1,167,679	20	17,580		77,745	1,170	14
15	27	Emp Ben - Mgmt Alloc	Bed Days Available	1,167,679	20	663,131		77,745	44,152	15
16	26	Insurance	Bed Days Available	1,167,679	20	62,063		77,745	4,132	16
17	34	Rental	Bed Days Available	1,167,679	20	750		77,745	50	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,984,650	\$ 6,821,316		\$ 531,624	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ReMED Services, LLC
Street Address 3450 8A
City / State / Zip Code _____
Phone Number ()
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	6	Repairs & Maintenance	Direct Allocation		\$	\$		\$ 5,664	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 5,664	25

Facility Name & ID Number Bella Terra Morton Grove # 0053223 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CF St. Louis, Inc.
Street Address 3450 Oakton St.
City / State / Zip Code Skokie, IL
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Bed Days Available	1,629,488	29	\$ 47,675	\$	77,958	\$ 2,281	1
2	6	Repairs & Maintenance	Bed Days Available	1,629,488	29	53,400		77,958	2,555	2
3	19	Professional Fees	Bed Days Available	1,629,488	29	19,171		77,958	917	3
4	19	Professional Fees	Bed Days Available	1,629,488	29	1,642		77,958	79	4
5	20	Dues, Fees, Subscriptions	Bed Days Available	1,629,488	29	76		77,958	4	5
6	20	Dues, Fees, Subscriptions	Bed Days Available	1,629,488	29	759		77,958	36	6
7	21	Clerical & General Other	Bed Days Available	1,629,488	29	678		77,958	32	7
8	26	Insurance	Bed Days Available	1,629,488	29	9,585		77,958	459	8
9	32	Interest	Bed Days Available	1,629,488	29	106,824		77,958	5,111	9
10	33	Real Estate Taxes	Bed Days Available	1,629,488	29	22,674		77,958	1,085	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					\$ 262,484	\$		\$ 12,559	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	The Private Bank	X		Mortgage	36,666	9/10/14	\$ 18,800,000	\$ 15,123,908	9/15/2017	Libor+0.04	\$ 795,426	1	
2	Greystone	X		Mortgage	Interest Only	9/30/14	2,350,000	1,940,116	12/15/2017	0.1100	216,969	2	
3	Capex	X		Mortgage	Interest Only	9/30/14	1,200,000	749,846	9/15/2017	Libor+0.0475	26,695	3	
4												4	
5												5	
	Working Capital												
6	The Private Bank		X	Operations LOC	Interest Only	9/30/15	0	1,035,000	9/29/2017	0.0487	43,555	6	
7												7	
8												8	
9	TOTAL Facility Related				\$36,666.00		\$ 22,350,000	\$ 18,848,870			\$ 1,082,645	9	
	B. Non-Facility Related*												
10								Allocated from Legacy HC Financial Serv				11	10
11								Allocated from Legacy Real Property			870	11	
12								Interest Income			(4,265)	12	
13								Allocated from CF St. Louis, Inc.			5,111	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 1,727	14	
15	TOTALS (line 9+line14)						\$ 22,350,000	\$ 18,848,870			\$ 1,084,372	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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bella Terra Morton Grove COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053223

CONTACT PERSON REGARDING THIS REPORT Chaim Rajchenbach

TELEPHONE (773) 248-6000 FAX #: (773) 248-9703

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 10-19-120-002-0000	Skilled nursing facility	\$ 711,796.81	\$ 711,796.81
2. 10-35-104-076-0000	Real estate entity	\$ 2,320.00	\$ 2,320.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 714,116.81	\$ 714,116.81

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

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

A. Square Feet: 92,175

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

Assisted Living Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ 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	Facility	183,600	2014	\$ 866,800	1
2	Allocated from Legacy Real Proper			3,914	2
3	TOTALS	183,600		\$ 870,714	3

Facility Name & ID Number Bella Terra Morton Grove

0053223

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	ALLOCATION OF PURCHASE PRICE		2014	1965	\$ 13,963,360	\$	40	\$ 349,084	\$ 349,084	\$ 785,439	4
5	Allocated from Legacy Real Properties		2009		30,325		30	1,125	1,125	7,581	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION OF PURCHASE PRICE			2014	200,000		30	6,667	6,667	15,000	9
10											10
11	Parking Lot Work: Milling, Install Primer Level, Patch			2015	38,487	2,566	15	2,566		3,849	11
12	Pave and Stripe - Orange Area										12
13	New trees, shrubs, bushes - Bella Terra North Sign Fork			2015	18,000	1,200	15	1,200		1,800	13
14	New Wood Flooring Installed			2015	14,969	499	30	499		748	14
15	Pro-Tech Roofing			2015	60,500	2,017	30	2,017		3,025	15
16											16
17	TriCore Environmental - Parking Lot			2015	34,180	1,139	30	1,139		1,709	17
18											18
19	Fire Alarm Panel - Mechanical Room			2015	6,118	204	30	204		306	19
20											20
21	Inspect and Rejuvenate Cooling Tower - Roof			2015	6,964	232	30	232		348	21
22											22
23	Carpet - Main Hallway			2015	13,636	455	30	455		682	23
24											24
25	Install Satellite Service for facility with 19 receivers			2015	2,866	96	30	96		143	25
26											26
27	Install Tile Flooring - Resident Rooms			2015	22,394	746	30	746	0	1,120	27
28											28
29	Facility signage - Front of Building			2015	19,331	644	30	644	0	967	29
30											30
31	Remove roof flashing, Install insulation and .060 mil. TPO			2015	4,800	160	30	160		240	31
32	Roof system - Over ramp area										32
33											33
34	2,212 Ivory Plank - Hallway			2015	5,123	171	30	171		256	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Bella Terra Morton Grove

0053223

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wood Plank Flooring - Hallway	2015	\$ 9,343	\$ 311	30	\$ 311		\$ 467	37
38									38
39	Redwood Sales Contract - Hallway	2015	39,491	1,316	30	1,316		1,975	39
40									40
41	Remove Wallpaper, Repair and Paint Walls. Install new doors. - Dining Room, Busn Office, PT Office	2015	9,820	327	30	327		491	41
42									42
43									43
44	Install Tile on Floor and Walls - Craft Room	2015	3,928	131	30	131		196	44
45									45
46	Hot Water Piping & Boiler Repair - Mechanical Room	2015	5,270	176	30	176		264	46
47									47
48	Facility Landscaping	2016	5,750	128	15	128		128	48
49									49
50	Computer Kiosks - Nursing Stations	2016	4,585	153	30	153		153	50
51									51
52	Facility Signage - Outside of building	2016	15,710	524	30	524		524	52
53	Facility Signage - Outside of building	2016	3,179	35		35		35	53
54	Tile - Kitchen, craft room, resident main dining room	2016	5,006	139	30	139		139	54
55									55
56	Painting - Bendix Wing	2016	25,567	710	30	710		710	56
57									57
58	Kitchen HVAC - Rooftop	2016	3,785	74	30	74		74	58
59									59
60	Room Signs - All rooms	2016	6,363	141	30	141		141	60
61									61
62	10 Sanitation Cabinets - isolation carts for entire facility	2016	2,500	56	30	56		56	62
63									63
64	29 Overbed Lights - Bendix Wing	2016	4,930	82	30	82		82	64
65									65
66	Doors - Rehab Wing	2016	3,030	34	30	34		34	66
67									67
68	New Flue pipes - Boiler Room	2016	3,586	20	30	20		20	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 14,592,897	\$ 14,486		\$ 371,362	\$ 356,876	\$ 828,701	70

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

Facility Name & ID Number Bella Terra Morton Grove

0053223

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,592,897	\$ 14,486		\$ 371,362	\$ 356,876	\$ 828,701	1
2									2
3	<u>Reroute Pipes - Boiler Room</u>	2016	7,660	43	30	43		43	3
4									4
5	<u>Boiler - New install boiler room</u>	2016	152,686	1,272	30	1,272		1,272	5
6									6
7	<u>Chiller - Basement Boiler Room</u>	2016	32,329	449	30	449		449	7
8									8
9	<u>Install vinyl cove base and chiller repair - Basement</u>	2016	6,870	115	30	115		115	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	<u>Allocated from Legacy Healthcare Financial Services, LLC</u>	2012	1,364		20	30	30	341	22
23	<u>Allocated from Legacy Healthcare Financial Services, LLC</u>	2013	4,364		20	95	95	873	23
24	<u>Allocated from Legacy Healthcare Financial Services, LLC</u>	2014	426		20	9	9	64	24
25	<u>Allocated from Legacy Healthcare Financial Services, LLC</u>	2015	587		20	13	13	59	25
26	<u>Allocated from Legacy Real Properties</u>	2009	17,221		20	278	278	5,812	26
27	<u>Allocated from Legacy Real Properties</u>	2010	5,237		20	85	85	1,363	27
28	<u>Allocated from Legacy Real Properties</u>	2011	7,443		20	120	120	2,233	28
29	<u>Allocated from CF. St. Louis Inc.</u>	2016	43,390		20			2,170	29
30									30
31	<u>To Reconcile to Book Depreciation</u>			(1,813)			1,813		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,872,474	\$ 14,552		\$ 373,871	\$ 359,319	\$ 843,495	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,349,096	\$	\$269,819	\$269,819	5	\$597,138	71
72	Current Year Purchases	171,559	57,643	34,312	(23,331)	5	34,312	72
73	Fully Depreciated Assets				-			73
74	See Sch 13A	33,492		1,344	1,344	10	10,003	74
75	TOTALS	\$1,554,147	\$57,643	\$305,475	\$247,832		\$641,453	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	2	
	Reference	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)	\$17,297,335	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$72,195	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$679,346	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$607,151	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,484,948	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	CIP	\$47,818	92
93			93
94			94
95		\$47,818	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 Morton Grove

IDPH License ID Number:

0053223

Fiscal Year End:

12/31/2015

Schedule 13A

XI. Ownership Costs

Line 74 - Equipment Costs - Excluding Transportation

Category of Equipment	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Component Life	Accumulated Depreciation
Allocation from LHFS, Inc	12,596		551		10	3,358
Allocated from Legacy Real Properties	7,897		793		10	5,346
Progressive	2,151				10	214
CF St. Louis, Inc.	10,848				10	1,085
TOTAL	33,492	-	1,344	-		10,003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				50			6
7	TOTAL				\$ 50			7

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

9. Option to Buy:
- ☐ YES
☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
☒ NO
16. Rental Amount for movable equipment: \$ 32,153
- Description: See Sch 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.		\$	79	17
18					18
19					19
20					20
21	TOTAL		\$	79	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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 Morton Grove

IDPH License ID Number:

0053223

Fiscal Year End:

12/31/2016

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copiers	169
Postage	383
Medical	24,810
Maintenance	6,791
Total - Line 16	32,153

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	\$	6,612	\$ 476,034	\$	6,612	\$ 476,034	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,486	106,991		1,486	106,991	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		7,983	574,742		7,983	574,742	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				329,394		329,394	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					3,324		3,324	12
13	Other (specify): <u>Ambulance</u>	39(3)			157	11,308		157	11,308	13
14	TOTAL			\$	16,238	\$ 1,169,075	\$ 332,718	16,238	\$ 1,501,793	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,547	\$ 3,547	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 480,487)	2,682,576	2,682,576	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	224,748	224,748	6
7	Other Prepaid Expenses	36,603	36,603	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A		123,837	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,947,474	\$ 3,071,311	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		870,714	13
14	Buildings, at Historical Cost		13,993,685	14
15	Leasehold Improvements, at Historical Cost	615,338	878,789	15
16	Equipment, at Historical Cost	423,979	1,554,147	16
17	Accumulated Depreciation (book methods)	(107,837)	(1,484,948)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		2,402,442	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(697,304)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Loan Fees		239,551	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 931,480	\$ 17,757,076	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,878,954	\$ 20,828,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,057,969	\$ 822,624	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	726,717	726,717	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,488	17,488	31
32	Accrued Real Estate Taxes(Sch.IX-B)		528,083	32
33	Accrued Interest Payable		86,300	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	190,394	1,315,803	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,992,568	\$ 3,497,015	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,035,000	18,848,870	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)	\$ 1,035,000	\$ 18,848,870	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,027,568	\$ 22,345,885	46
47	TOTAL EQUITY(page 18, line 24)	\$ 851,386	\$ (1,517,498)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,878,954	\$ 20,828,387	48

*(See instructions.)

Facility Name: Bella Terra Morton Grove
IDPH License ID Number: 0053223
Fiscal Year End: 12/31/2016

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

		After
Description	Operating	Consolidation
Escrow	-	123,837
Total - Line 9	-	123,837

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

		After
Description	Operating	Consolidation
Due to/from Related	-	(1,523,392)
Due to/from MG Prop Hold	-	542,460
Due to/from prior owner	-	(144,477)
Resident Fund	(6,812)	(6,812)
Refund Transfer	19,424	19,424
Payroll Exchange	(9,017)	(9,017)
Due to/from Bella Terra Morton Grove & Management	691,490	691,490
Due to/from Bella Terra Morton Grove & Avantara	(30)	(30)
Due to/from Bella Terra Morton Grove & ALF	275,809	275,809
Due to/from Morton Grove & Warren Barr	39,451	39,451
Due to/from Warren Barr Lincolnshire	(356,920)	(356,920)
Due to/from Welshire Lincolnshire & Bella Terra	(40,000)	(40,000)
Due to/from Propco	(542,459)	(542,459)
Due to/from prior owner	(11,893)	(11,893)
Due to/from others	46,000	46,000
Accrued Expense	(122,433)	(122,433)
Accrued management fees entities	(282,729)	(282,729)
Due to/from Medicare	109,270	109,270
Patient - Personal Items	455	455
Total - Line 36	(190,394)	(1,315,803)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 477,774	1
2	Restatements (describe):		2
3	Post closing adjustment	(174,236)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 303,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	547,848	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)	\$ 547,848	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)	\$ 851,386	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bella Terra Morton Grove

0053223

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 17,264,951	1
2	Discounts and Allowances for all Levels	(6,717,973)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,546,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,826,610	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,826,610	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	305,920	17
18	Sale of Supplies to Non-Patients	9,542	18
19	Laboratory	90,667	19
20	Radiology and X-Ray	17,685	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 423,814	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,265	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,265	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Discounts Earned</u>	4,532	28
28a	<u>Misc Income</u>	14,471	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,003	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,820,670	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,212,232	31
32	Health Care	4,861,494	32
33	General Administration	3,513,796	33
	B. Capital Expense		
34	Ownership	2,117,040	34
	C. Ancillary Expense		
35	Special Cost Centers	2,166,660	35
36	Provider Participation Fee	401,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,272,822	40
41	Income before Income Taxes (line 30 minus line 40)**	547,848	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 547,848	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,851,610	44
45	Private Pay - Net Inpatient Revenue	3,164,093	45
46	Medicare - Net Inpatient Revenue	2,003,926	46
47	Other-(specify) <u>Insurance</u>	316,409	47
48	Other-(specify) <u>Medicaid Pending</u>	210,940	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,546,978	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.

^ - This entity is a cash basis taxpayer

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,782	2,047	\$ 93,225	\$ 45.54	1
2	Assistant Director of Nursing	1,920	2,106	84,648	40.19	2
3	Registered Nurses	32,044	35,984	1,155,013	32.10	3
4	Licensed Practical Nurses	27,241	30,055	794,728	26.44	4
5	CNAs & Orderlies	106,507	118,304	1,625,414	13.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,275	6,899	142,451	20.65	8
9	Activity Director					9
10	Activity Assistants	16,609	17,441	214,475	12.30	10
11	Social Service Workers	3,511	4,127	91,698	22.22	11
12	Dietician					12
13	Food Service Supervisor	8,233	8,561	145,238	16.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	40,775	44,071	498,553	11.31	15
16	Dishwashers					16
17	Maintenance Workers	5,030	5,582	108,386	19.42	17
18	Housekeepers	25,316	27,249	294,665	10.81	18
19	Laundry	7,203	8,062	97,385	12.08	19
20	Administrator	2,006	2,255	105,351	46.72	20
21	Assistant Administrator	2,635	2,689	97,876	36.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,634	22,152	561,392	25.34	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	2,030	2,080	46,987	22.59	31
32	Other Health Care See Sch 20A	5,659	6,250	206,417	33.03	32
33	Other(specify) See Sch 20A	2,842	3,235	70,792	21.88	33
34	TOTAL (lines 1 - 33)	323,252	349,149	\$ 6,434,694 *	\$ 18.43	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	\$ (500)	1(3)	35
36	Medical Director	Monthly	95,722	9(3)	36
37	Medical Records Consultant	Monthly	1,200	10(3)	37
38	Nurse Consultant	Monthly	1,154	10(3)	38
39	Pharmacist Consultant	Monthly	12,090	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	15,106	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,072	11(3)	44
45	Social Service Consultant	Monthly	2,450	12(3)	45
46	Other(specify) MDS Consultant	Monthly	38,235	10(3)	46
47	Clergy Consultant	Monthly	4,095	12(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 170,624		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	5	80	10(3)	52
53	TOTAL (lines 50 - 52)	5	\$ 80		53

Facility Name: Bella Terra Morton Grove
IDPH License ID Number: 0053223
Fiscal Year End: 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Alzheimer Supervisor RN	1,542	1,789	50,827	\$ 28.41
MDS/Care Plan Coordinator LPN	868	952	30,231	\$ 31.76
MDS/Care Plan Coordinator RN	3,249	3,509	125,359	\$ 35.72
Total - Line 32 Other Health Care (specify):	5,659	6,250	206,417	\$ 33.03

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coord(Asst/Clerk)	45	76	2,570	\$ 33.82
Admissions Director	1,209	1,254	27,620	\$ 22.03
Guest Services Aide	1,238	1,504	31,649	\$ 21.04
Guest Services Director	350	401	8,953	\$ 22.33
Total - Line 33 Other (specify):	2,842	3,235	70,792	\$ 21.88

STATE OF ILLINOIS

Facility Name & ID NumberBella Terra Morton Grove# 0053223Report Period Beginning:01/01/2016Ending:12/31/2016Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sinead O'Sullivan	Administrator	0	\$ 90,573
Alba Galindo	Asst Administrator	0	107,493
Kalman Lebovics	Asst Administrator	0	5,161
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 203,227

B. Administrative - Other

Description	Amount
Management Fees	\$ 939,379
(Eliminated in Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	Professional Services	\$ 174,966
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 174,966

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 169,413
Unemployment Compensation Insurance	107,461
FICA Taxes	430,599
Employee Health Insurance	216,148
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	15,872
Payroll Taxes	37,924
PTO Adjustment	16,103
Uniforms	13,659
Other Benefits	72,025
Allocated from Mgmt Co.	(25,154)
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$ 1,990
Advertising: Employee Recruitment	56
Health Care Worker Background Check (Indicate # of checks performed 789)	9,473
Illinois Council on Long Term Care	1,509
Miscellaneous Licenses & Fees	12,426
Miscellaneous Dues & Subscriptions	22,492
Allocated from Mgmt Co	3,308
Less : Lobbying Expense	(498)
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,713
Allocated from Mgmt. Co	2,931
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,644

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name: Bella Terra Morton Grove
IDPH License ID Number: 0053223
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Legacy Healthcare	Consultant	2,817
RSM US LLP	Accounting	28,232
MLGroup Design & Development	Asset Management Fees	15,123
Achieve Accreditation Llc	Other Professional Fees	8,416
Chicago Backflow Inc	Other Professional Fees	830
Corporation Service Company	Other Professional Fees	103
Cukierski & Kowal, Llc	Other Professional Fees	498
Deborah Cole Byrd	Other Professional Fees	500
Environmental Monitoring & Tec	Other Professional Fees	2,645
First Real Estate Services Ltd	Other Professional Fees	2,063
Global Water Technology, Inc	Other Professional Fees	335
Heartland Health Outreach	Other Professional Fees	18
Illinois Rytes Corp	Other Professional Fees	9,000
Legacy Reimbursement	Other Professional Fees	5,206
Lexisnexis Risk Solutions	Other Professional Fees	64
Lighthouse Services, Inc	Other Professional Fees	301
Meyer Magence	Other Professional Fees	63
MLGroup Design & Development	Other Professional Fees	853
Paycor Fees	Other Professional Fees	28,867
Personnel Planners Inc	Other Professional Fees	1,650
Prepaid Expense	Other Professional Fees	8,417
Prospect Resources Inc	Other Professional Fees	1,000
Psd Solutions	Other Professional Fees	4,501
Shkop Financial Services	Other Professional Fees	217
Meyer Magence	Legal	188
Meyer Magence	Legal	188
Stone Pogrund & Korey LLC	Legal	200
Stone Pogrund & Korey LLC	Legal	465
Stone Pogrund & Korey LLC	Legal	800
Stone Pogrund & Korey LLC	Legal	1,383
Stone Pogrund & Korey LLC	Legal	463
Stone Pogrund & Korey LLC	Legal	75
Stone Pogrund & Korey LLC	Legal	250
Stone Pogrund & Korey LLC	Legal	75
Stone McGuire & Siegel	Legal	821
Meltzer, Purtill & Stelle LLC	Legal	2,498
Neal, Gerber, & Eisenberg LLP	Legal	170
Meltzer, Purtill & Stelle LLC	Legal	2,444
Neal, Gerber, & Eisenberg LLP	Legal	114
Kitch Drutchas Wagner Valitutt	Legal	74
Much Shelist	Legal	73
Ober, Kaler, Grimes, & Shriver	Legal	145
Ober, Kaler, Grimes, & Shriver	Legal	376
Stone Pogrund & Korey LLC	Legal	200
Stone Pogrund & Korey LLC	Legal	50
Stone Pogrund & Korey LLC	Legal	288
Stone Pogrund & Korey LLC	Legal	75
Documentation Solutions Inc.	Legal	1,235
Documentation Solutions Inc.	Legal	1,235
Documentation Solutions Inc.	Legal	1,519
Documentation Solutions Inc.	Legal	943
Illinois Rytes Bill	Legal	1,079
Prepaid Expenses	Legal	24,324
Legacy Reimbursement	Legal	11,499
Total (agree to Schedule V, line 19, column 3)		174,966
Allocated from Management Company Legal Fees		4,090
Allocated from Management Company Professional Services		35,070
Allocated from Management Company Accounting Fees		412
Less: Non-Allowable Legal Fees		(233)
Total (agree to Schedule V, line 19, column 8)		214,305

XX. GENERAL INFORMATION:

(1)

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

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
Illinois Council for Long-Term Care \$1,509

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
30 Years

(6)

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

\$ 58,155 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 401,600

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
No Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ N/A

c.

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

0%

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?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

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

Yes
RSM US LLP

(18)

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

Yes

(19)

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

Yes