

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0055962

Facility Name: Bella Terra Wheeling

Address: 730 West Hintz Road Wheeling 60090
Number City Zip Code

County: Cook

Telephone Number: (847-537-7474) Fax # (847-537-7599)

HFS ID Number:

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

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: John Ennerson Telephone Number: (312) 344-2883
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) John Epperson Principal
(Firm Name & Address) Miller Cooper & Co., Ltd. 3 Parkway North, Suite 200, Deerfield IL 60015
(Telephone) (312) 344-2883 Fax # ()

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

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	<u>214</u>	Skilled (SNF)	<u>214</u>	<u>78,110</u>	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	<u>214</u>	TOTALS	<u>214</u>	<u>78,110</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF				58		3,678	316	4,052	8
9	SNF/PED									9
10	ICF	21,186	22,335	8,596		7,431			59,548	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	21,186	22,335	8,596	58	7,431	3,678	316	63,600	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.42%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 09/01/2019

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 09/01/2019 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 214

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		66,834	1,212,164	1,278,998		1,278,998	315	1,279,313			1
2	Food Purchase		6,669		6,669		6,669	(1,745)	4,924			2
3	Housekeeping	748,828	38,864		787,692		787,692	711	788,403			3
4	Laundry	241,747	31,460		273,207		273,207		273,207			4
5	Heat and Other Utilities			341,515	341,515		341,515	(22,106)	319,409			5
6	Maintenance	84,526	20,709	176,183	281,418		281,418	14,133	295,551			6
7	Other (specify):*							1,144	1,144			7
8	TOTAL General Services	1,075,101	164,536	1,729,862	2,969,499		2,969,499	(7,548)	2,961,951			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000	7,040	37,040			9
10	Nursing and Medical Records	6,538,963	151,055	916,713	7,606,731		7,606,731	118,375	7,725,106			10
10a	Therapy	320,650			320,650		320,650	3,194	323,844			10a
11	Activities	223,934	13,116	4,265	241,315		241,315	133	241,448			11
12	Social Services	142,393		7,061	149,454		149,454	2,609	152,063			12
13	CNA Training											13
14	Program Transportation	41,993			41,993		41,993		41,993			14
15	Other (specify):*							19,977	19,977			15
16	TOTAL Health Care and Programs	7,267,933	164,171	958,039	8,390,143		8,390,143	151,328	8,541,471			16
	C. General Administration											
17	Administrative	207,682			207,682		207,682	59,690	267,372			17
18	Directors Fees											18
19	Professional Services			204,313	204,313		204,313	103,785	308,098			19
20	Dues, Fees, Subscriptions & Promotions			93,304	93,304		93,304	(42,184)	51,121			20
21	Clerical & General Office Expenses	472,554	3,312	662,776	1,138,642		1,138,642	(68,172)	1,070,470			21
22	Employee Benefits & Payroll Taxes			1,118,504	1,118,504		1,118,504		1,118,504			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,046	2,046		2,046	1,058	3,104			24
25	Other Admin. Staff Transportation							4,013	4,013			25
26	Insurance-Prop.Liab.Malpractice			549,135	549,135		549,135	9,019	558,154			26
27	Other (specify):*							36,606	36,606			27
28	TOTAL General Administration	680,236	3,312	2,630,078	3,313,626		3,313,626	103,815	3,417,441			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,023,270	332,019	5,317,979	14,673,268		14,673,268	247,595	14,920,863			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							156,317	156,317			30
31	Amortization of Pre-Op. & Org.			129,364	129,364		129,364		129,364			31
32	Interest			34,715	34,715		34,715	817,843	852,558			32
33	Real Estate Taxes			994,048	994,048		994,048	(40,493)	953,555			33
34	Rent-Facility & Grounds			1,302,987	1,302,987		1,302,987	(1,283,064)	19,923			34
35	Rent-Equipment & Vehicles			13,661	13,661		13,661	1,871	15,532			35
36	Other (specify):*							96,255	96,255			36
37	TOTAL Ownership			2,474,775	2,474,775		2,474,775	(251,271)	2,223,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		466,662	866,858	1,333,520		1,333,520		1,333,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			1,025,326	1,025,326		1,025,326	(1,025,326)				43
44	TOTAL Special Cost Centers		466,662	1,892,184	2,358,846		2,358,846	(1,025,326)	1,333,520			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,023,270	798,681	9,684,938	19,506,889		19,506,889	(1,029,002)	18,477,887			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	(23,412)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,608	30		9
10	Interest and Other Investment Income	(16,593)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,745)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(42,180)	21		18
19	Entertainment	(1,009)	21		19
20	Contributions	(19,143)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(257,597)	21		24
25	Fund Raising, Advertising and Promotional	(17,160)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,106,126)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,464,357)		\$	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)	703,766		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 703,766		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (760,591)		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	Political Action Committee Payments	\$ (7,979)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Expense	(1,025,326)	43	3
4	Bank Charges	(26,630)	21	4
5	Patient Personal Items	(1,780)	10	5
6	Sequestration Expense	(59,786)	21	6
7	Non-Allowable Legal	26,824	19	7
8	Building Co. - Filing Fees	0	21	8
9	Building Co. - Amortization	(3,699)	36	9
10	Building Co. - Professional fees	(7,750)	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	(1,106,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	315	0	0	0	0	0	0	0	0	315	1
2	Food Purchase	(1,745)	0	0	0	0	0	0	0	0	0	0	(1,745)	2
3	Housekeeping	0	0	711	0	0	0	0	0	0	0	0	711	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(23,412)	0	736	570	0	0	0	0	0	0	0	(22,106)	5
6	Maintenance	0	0	13,498	717	(82)	0	0	0	0	0	0	14,133	6
7	Other (specify):*	0	0	1,144	0	0	0	0	0	0	0	0	1,144	7
8	TOTAL General Services	(25,157)	0	16,404	1,287	(82)	0	0	0	0	0	0	(7,548)	8
	B. Health Care and Programs													
9	Medical Director	0	0	7,040	0	0	0	0	0	0	0	0	7,040	9
10	Nursing and Medical Records	(1,780)	0	121,624	0	0	(1,469)	0	0	0	0	0	118,375	10
10a	Therapy	0	0	3,194	0	0	0	0	0	0	0	0	3,194	10a
11	Activities	0	0	133	0	0	0	0	0	0	0	0	133	11
12	Social Services	0	0	2,609	0	0	0	0	0	0	0	0	2,609	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	19,977	0	0	0	0	0	0	0	0	19,977	15
16	TOTAL Health Care and Programs	(1,780)	0	154,577	0	0	(1,469)	0	0	0	0	0	151,328	16
	C. General Administration													
17	Administrative	0	0	59,690	0	0	0	0	0	0	0	0	59,690	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	19,074	7,750	84,811	57	0	0	(7,907)	0	0	0	0	103,785	19
20	Fees, Subscriptions & Promotions	(44,282)	0	2,098	0	0	0	0	0	0	0	0	(42,184)	20
21	Clerical & General Office Expenses	(387,202)	0	318,981	49	0	0	0	0	0	0	0	(68,172)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,058	0	0	0	0	0	0	0	0	1,058	24
25	Other Admin. Staff Transportation	0	0	4,013	0	0	0	0	0	0	0	0	4,013	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,848	171	0	0	0	0	0	0	0	9,019	26
27	Other (specify):*	0	0	36,606	0	0	0	0	0	0	0	0	36,606	27
28	TOTAL General Administration	(412,410)	7,750	516,105	277	0	0	(7,907)	0	0	0	0	103,815	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(439,347)	7,750	687,086	1,564	(82)	(1,469)	(7,907)	0	0	0	0	247,595	29

Summary B

Facility Name & ID Number

0055962

01/01/2025

12/31/2025

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	20,608	133,204	0	2,505	0	0	0	0	0	0	0	156,317	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,593)	836,027	(3,165)	1,574	0	0	0	0	0	0	0	817,843	32
33	Real Estate Taxes	0	(42,359)	0	1,866	0	0	0	0	0	0	0	(40,493)	33
34	Rent-Facility & Grounds	0	(1,302,987)	19,923	0	0	0	0	0	0	0	0	(1,283,064)	34
35	Rent-Equipment & Vehicles	0	0	1,871	0	0	0	0	0	0	0	0	1,871	35
36	Other (specify):*	(3,699)	99,954	0	0	0	0	0	0	0	0	0	96,255	36
37	TOTAL Ownership	316	(276,161)	18,629	5,945	0	0	0	0	0	0	0	(251,271)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,025,326)	0	0	0	0	0	0	0	0	0	0	(1,025,326)	43
44	TOTAL Special Cost Centers	(1,025,326)	0	0	0	0	0	0	0	0	0	0	(1,025,326)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,464,357)	(268,411)	705,715	7,509	(82)	(1,469)	(7,907)	0	0	0	0	(1,029,002)	45

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 Ownership Listing-1		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,302,987	Wheeling Property Holdings, LLC		\$	(1,302,987)	1
2	V	33	Real Estate Taxes	994,048	Wheeling Property Holdings, LLC		951,689	(42,359)	2
3	V	32	Interest	34,715	Wheeling Property Holdings, LLC		870,742	836,027	3
4	V	36	Mortgage Insurance Premium		Wheeling Property Holdings, LLC		96,255	96,255	4
5	V	21	Filing Fees		Wheeling Property Holdings, LLC		0		5
6	V	30	Depreciation		Wheeling Property Holdings, LLC		133,204	133,204	6
7	V	36	Amortization		Wheeling Property Holdings, LLC		3,699	3,699	7
8	V	19	Professional fees		Wheeling Property Holdings, LLC		7,750	7,750	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,331,750			\$ 2,063,339	\$ * (268,411)	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:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Astoria Place Living and Rehab	Chicago, IL	Bella Terra Streamwood	Streamwood, IL	Wheeling Property Ho	Illinois	Building Company	1
2	Avantara Arrowhead	Rapid City, SD	Bella Terra Wheeling	Wheeling, IL	Legacy HC & Financial	Skokie	Home Office/Book	2
3	Avantara Aurora	Aurora, IL	Carlton at the Lake	Chicago, IL	CF St. Louis LLC	Skokie	Building Company	3
4	Avantara Chicago Ridge	Chicago Ridge, IL	Chalet Living and Rehab	Chicago, IL	ML Group Design & I	Skokie	Asset Management	4
5	Avantara Clark City	Clark, SD	Cardinal Grove Independent & Assisted Living	Garner, IA	ReMED Services LLC	Skokie	Nursing Equipment	5
6	Avantara of Elgin	Elgin, IL	Glenview Terrace	Glenview, IL	Propay HR	Evanston	Payroll Processing	6
7	Avantara Evergreen Park	Evergreen Park, IL	Harmony Cedar Rapids	Cedar Rapids, IA				7
8	Avantara Groton	Groton, SD	Harmony Davenport	Davenport, IA				8
9	Avantara Huron	Huron, SD	Harmony Dubuque	Dubuque, IA				9
10	Avantara Lake Norden	Lake Norden, SD	Harmony Marshalltown	Marshalltown, IA				10
11	Avantara Lake Zurich	Lake Zurich, IL	Harmony Healthcare & Rehabilitation Center	Chicago, IL				11
12	Avantara Libertyville	Libertyville, IL	Harmony Palos	Palos Heights, IL				12
13	Avantara Lincoln Park	Chicago, IL	Harmony Utica Ridge	Davenport, IA				13
14	Avantara Long Grove	Long Grove, IL	Harmony Waterloo	Waterloo, IA				14
15	Avantara Milbank	Milbank, SD	Harmony West Des Moines	West Des Moines, IA				15
16	Avantara Mountain View	Rapid City, SD	Lakefront	Chicago, IL				16
17	Avantara North	Rapid City, SD	Peterson Park Health Care Center	Chicago, IL				17
18	Avantara Norton	Rapid City, SD	Grove at the Lake	Zion, IL				18
19	Avantara Palos Heights	Palos Heights, IL	Harmony House Care Center ICF	Waterloo, IA				19
20	Avantara Park Ridge	Park Ridge, IL	The Grove of Elmhurst	Elmhurst, IL				20
21	Avantara Pierre	Pierre, SD	The Grove of Evanston	Evanston, IL				21
22	Avantara Redfield	Redfield, SD	The Grove of Fox Valley	Aurora, IL				22
23	Avantara Saint Cloud	St. Cloud, MN	The Grove of La Grange Park	La Grange Park, IL				23
24	Avantara Watertown	Watertown, SD	The Grove of Northbrook	Northbrook, IL				24
25	Bella Terra Bloomingdale	Bloomingdale, IL	The Grove of Skokie	Skokie, IL				25
26	Bella Terra Elmhurst	Elmhurst, IL	Grove of St. Charles	St. Charles, IL				26
27	Bella Terra La Grange	La Grange, IL	Vistas Fox Valley	Aurora, IL				27
28	Bella Terra Lombard	Lombard, IL	Vistas of Lincoln Park	Chicago, IL				28
29	Bella Terra Morton Grove	Morton Grove, IL	Wellshire Morton Grove	Morton Grove, IL				29
30	Bella Terra Schaumburg	Schaumburg, IL	Warren Barr Buffalo Grove	Buffalo Grove, IL				30

Facility Name & ID Number

Bella Terra Wheeling

0055962

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Warren Barr Gold Coast	Chicago, IL	Nora Springs Care Center	Nora Springs, IA				1
2	Warren Barr Lieberman	Skokie, IL	Grandview Care Center	Oelwein, IA				2
3	Warren Barr Lincoln Park	Chicago, IL	Oelwein Healthcare Center	Oelwein, IA				3
4	Warren Barr North Shore	Highland Park, IL	Park View Care Center	Sac City, IA				4
5	Whitehall	Deerfield, IL	Manor House Care Center	Sigourney, IA				5
6	Warren Barr Orland Park	Orland Park, IL	Main Street Manor	Swea City, IA				6
7	Warren Barr South Loop	Chicago, IL	Harmony House Care Center SNF	Waterloo, IA				7
8	Wellshire Huron	Huron, SD	Northgate Care Center	Waukon, IA				8
9	Wellshire Park Place	Milbank, SD	Southfield Wellness Community	Webster City, IA				9
10	Warren Barr Oak Lawn	Oak Lawn, IL	Avantara Joliet	Joliet, IL				10
11	Rehab Center Of Allison	Allison, IA	Harmony Park Ridge	Park Ridge, IL				11
12	Maple Manor Village	Aplington, IA	Mulberry Place Independent & Assisted Living	Bloomfield, IA				12
13	Valley Vue Care Center	Armstrong, IA	Afton Oaks Independent & Assisted Living	Elma, IA				13
14	Willow Dale Wellness Village	Battle Creek, IA	Southfield Wellness Community Independent &	Webster City, IA				14
15	Rehab Center Of Belmond	Belmond, IA	Emerald Oaks Independent & Assisted Living	Emmetsburg, IA				15
16	Bloomfield Care Center	Bloomfield, IA	Eagle Ridge Assisted Living Apartments	Guttenberg, IA				16
17	Westview Care Center	Britt, IA	Cherry Ridge Independent & Assisted Living	Mount Vernon, IA				17
18	Oakwood Care Center	Clear Lake, IA	Mills Harbor Assisted Living Lake	Lake Mills, IA				18
19	Colonial Manor Of Elma	Elma, IA	Deer View Manor Independent & Assisted Living	Sigourney, IA				19
20	Emmetsburg Care Center	Emmetsburg, IA	Maple Manor Village Independent & Assisted Living	Aplington, IA				20
21	Concord Care Center	Garner, IA	Summit Heights	Nora Springs, IA				21
22	Guttenberg Care Center	Guttenberg, IA	Southercrest Manor II Assisted Living	Waukon, IA				22
23	Rehab Center Of Hampton	Hampton, IA	The Courtyard	West Des Moines, IA				23
24	Rehab Center Of Independence-West	Independence, IA	Park Place Independent & Assisted Living	Sac City, IA				24
25	Westview Of Indianola	Indianola, IA	Elm Springs	Arkansas, IA				25
26	Rehab Center Of Lisbon	Lisbon, IA	Belle Haven Independent & Assisted Living	Blemond, IA				26
27	Lake Mills Care Center	Lake Mills, IA	Leahy Grove Independent & Assisted Living	Hampton, IA				27
28	Heritage Health & Rehab Center	Cedar Rapids, IA	Indian Creek Independent & Assisted Living	Nevada, IA				28
29	Hallmark Care Center	Mt Vernon, IA	Spring Creek Independent & Assisted Living	Armstrong, IA				29
30	Rolling Green Village	Nevada, IA	Clark SNF	Clark St, IL				30

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Elmbrook SNF	Elmhurst, IL						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								25
26								26
27								27
28								28
29								29
30								30

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	1	Dietary	\$	Legacy Healthcare Financial Services		\$ 315	\$ 315	15
16	V	3	Housekeeping		Legacy Healthcare Financial Services		711	711	16
17	V	5	Heat and other Utilities		Legacy Healthcare Financial Services		736	736	17
18	V	6	Maintenece		Legacy Healthcare Financial Services		13,498	13,498	18
19	V	7	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		1,144	1,144	19
20	V	9	Medical Director		Legacy Healthcare Financial Services		7,040	7,040	20
21	V	10	Nursing and Medical Records		Legacy Healthcare Financial Services		121,624	121,624	21
22	V	10A	Therapy		Legacy Healthcare Financial Services		3,194	3,194	22
23	V	11	Activities		Legacy Healthcare Financial Services		133	133	23
24	V	12	Social Services		Legacy Healthcare Financial Services		2,609	2,609	24
25	V	15	Other (specify):*Employee Benefits		Legacy Healthcare Financial Services		19,977	19,977	25
26	V	17	Administrative		Legacy Healthcare Financial Services		59,690	59,690	26
27	V	19	Professional Services		Legacy Healthcare Financial Services		84,811	84,811	27
28	V	20	Dues, Fees, Subscriptions & Promotions		Legacy Healthcare Financial Services		2,098	2,098	28
29	V	21	Clerical & General Office Expenses		Legacy Healthcare Financial Services		318,981	318,981	29
30	V	24	Travel and Seminar		Legacy Healthcare Financial Services		1,058	1,058	30
31	V	25	Other Admin. Staff Transportation		Legacy Healthcare Financial Services		4,013	4,013	31
32	V	26	Insurance-Prop.Liab.Malpractice		Legacy Healthcare Financial Services		8,848	8,848	32
33	V	27	Other (specify):* Employee Benefits		Legacy Healthcare Financial Services		36,606	36,606	33
34	V	32	Interest		Legacy Healthcare Financial Services		(3,165)	(3,165)	34
35	V	34	Rent-Facility & Grounds		Legacy Healthcare Financial Services		19,923	19,923	35
36	V	35	Equipment Rental		Legacy Healthcare Financial Services		230	230	36
37	V	35	Auto Rental		Legacy Healthcare Financial Services		1,641	1,641	37
38	V								38
39	Total			\$			\$ 705,715	\$ * 705,715	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	5	Utilities	\$	CF St. Louis LLC		\$ 570	\$ 570	15
16	V	6	Repairs and Maintenance		CF St. Louis LLC		717	717	16
17	V	19	Real Estate Appraisal Fee		CF St. Louis LLC		57	57	17
18	V	20	Professional Fees		CF St. Louis LLC		0		18
19	V	21	Office Expense		CF St. Louis LLC		49	49	19
20	V	26	Insurance		CF St. Louis LLC		171	171	20
21	V	30	Depreciation		CF St. Louis LLC		2,505	2,505	21
22	V	32	Interest Expense		CF St. Louis LLC		1,574	1,574	22
23	V	33	Real Estate Taxes		CF St. Louis LLC		1,866	1,866	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			\$			\$ 7,509	\$ * 7,509	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	Maintenance	\$ 6,000	ML Group Design and Development		\$ 5,918	\$ (82)	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			\$ 6,000			\$ 5,918	\$ * (82)	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	10	Medical Supplies	\$ 21,699	ReMED Services		\$ 20,230	\$ (1,469)	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			\$ 21,699			\$ 20,230	\$ * (1,469)	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	Payroll Service	\$ 34,712	ProPay HR LLC		\$ 26,805	\$ (7,907)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 34,712			\$ 26,805	\$ * (7,907)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Bella Terra Wheeling								
ID#		0055962						
Report Period Beginning:		01/01/2025			Legacy Healthcare FS			
Ending:		12/31/2025			Wheeling Property Holdings, LLC			
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Management			
-Owners of companies must be listed instead of company names.					Co./Home Office			
-Names of trust beneficiaries must be listed.								
First Name	M.I.	Last Name	City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Co./Home Office Ownership Percentage	
1	GPN Family Trust							1
2	Beneficiary							2
3	Rivka	Rajchenbach	Chicago	IL	10.62500	14.87500		3
4	Bella	Rajchenbach	Chicago	IL	10.62500	14.87500		4
5	Yitzchok	Rajchenbach	Chicago	IL	10.62500	14.87500		5
6	Ziskind	Rajchenbach	Chicago	IL	10.62500	14.87500		6
7								7
8	Oakway Operations LLC							8
9	Daniel	Garden	Chicago	IL	4.90000	4.90000		9
10	Rebecca	Garden	Chicago	IL	2.60000	2.60000		10
11	Mordechay	Ninio	Chicago	IL	4.90000	4.90000		11
12	Sherie	Ninio	Chicago	IL	2.60000	2.60000		12
13								13
14	Doros Generation Trust							14
15	Beneficiary							15
16	Ahuva	Shabat	Lincolnwood	IL	8.50000	5.10000		16
17	Eliana	Shabat	Lincolnwood	IL	8.50000	5.10000		17
18	Ayalet	Shabat	Lincolnwood	IL	8.50000	5.10000		18
19	Ashira	Shabat	Lincolnwood	IL	8.50000	5.10000		19
20	Leora	Shabat	Lincolnwood	IL	8.50000	5.10000		20
21								21
22	Legacy Healthcare Financial Service							22
23	Chaim	Rajchenbach	Chicago	IL			50.00000	23
24	Menachem	Shabat	Lincolnwood	IL			50.00000	24
25								25
26	CCG Kalambo Falls, LLC							26
27								27
28								28
29								29
30								30
31								31
32								32
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74								74
75								75

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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Census Days / Direct Allocation	121	121	\$ 17,417	\$ 188,860		\$ 315	1
2	3	Housekeeping	Census Days / Direct Allocation	121	121	39,313			711	2
3	5	Heat and other Utilities	Census Days / Direct Allocation	121	121	40,732			736	3
4	6	Maintenece	Census Days / Direct Allocation	121	121	1,086,339			13,498	4
5	7	Other (specify):*Employee Benefit	Census Days / Direct Allocation	121	121	115,823			1,144	5
6	9	Medical Director	Census Days / Direct Allocation	121	121	389,400	1,007,031		7,040	6
7	10	Nursing and Medical Records	Census Days / Direct Allocation	121	121	7,945,861	12,523,114		121,624	7
8	10A	Therapy	Census Days / Direct Allocation	121	121	176,684	152,483		3,194	8
9	11	Activities	Census Days / Direct Allocation	121	121	7,371			133	9
10	12	Social Services	Census Days / Direct Allocation	121	121	144,309	144,309		2,609	10
11	15	Other (specify):*Employee Benefit	Census Days / Direct Allocation	121	121	1,241,625			19,977	11
12	17	Administrative	Census Days / Direct Allocation	121	121	5,453,317			59,690	12
13	19	Professional Services	Census Days / Direct Allocation	121	121	4,691,102	5,453,317		84,811	13
14	20	Dues, Fees, Subscriptions & Prom	Census Days / Direct Allocation	121	121	116,052			2,098	14
15	21	Clerical & General Office Expense	Census Days / Direct Allocation	121	121	20,639,396	19,821,678		318,981	15
16	24	Travel and Seminar	Census Days / Direct Allocation	121	121	58,495			1,058	16
17	25	Other Admin. Staff Transportatio	Census Days / Direct Allocation	121	121	221,955			4,013	17
18	26	Insurance-Prop.Liab.Malpractice	Census Days / Direct Allocation	121	121	489,395			8,848	18
19	27	Other (specify):* Employee Benefi	Census Days / Direct Allocation	121	121	2,646,369			36,606	19
20	32	Interest	Census Days / Direct Allocation	121	121	(175,042)			(3,165)	20
21	34	Rent-Facility & Grounds	Census Days / Direct Allocation	121	121	1,102,008			19,923	21
22	35	Equipment Rental	Census Days / Direct Allocation	121	121	12,712			230	22
23	35	Auto Rental	Census Days / Direct Allocation	121	121	90,802			1,641	23
24										24
25	TOTALS					\$ 46,551,435	\$ 39,290,792		\$ 705,715	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	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	Census Days	3,517,851	121	\$ 31,540	\$	63,600	\$ 570	1
2	6	Repairs and Maintenance	Census Days	3,517,851	121	39,680		63,600	717	2
3	19	Real Estate Appraisal Fee	Census Days	3,517,851	121	3,155		63,600	57	3
4	20	Professional Fees	Census Days	3,517,851	121			63,600		4
5	21	Office Expense	Census Days	3,517,851	121	2,733		63,600	49	5
6	26	Insurance	Census Days	3,517,851	121	9,443		63,600	171	6
7	30	Depreciation	Census Days	3,517,851	121	138,584		63,600	2,505	7
8	32	Interest Expense	Census Days	3,517,851	121	87,057		63,600	1,574	8
9	33	Real Estate Taxes	Census Days	3,517,851	121	103,201		63,600	1,866	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					\$ 415,393	\$		\$ 7,509	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ML Group Design and Development
Street Address 3424 Oakton St.
City / State / Zip Code Skokie, IL 60076
Phone Number (847) 676-5300
Fax Number (847) 676-5348

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct			\$	\$		\$(82)	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					\$	\$		\$(82)	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Medical Supplies	Direct			\$	\$		\$ 20,230	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					\$	\$		\$ 20,230	25

Facility Name & ID Number Bella Terra Wheeling # 0055962 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			\$	\$		\$ 26,805	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 26,805	25

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	CIBC		X	Mortgage Payable			\$	14,738,266			\$	870,742	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Forbright Bank		X	Revolving Line of Credit				1,063,271				156,101	6	
7	IPFS Corporation		X	Prepaid Insurance - Interest Only								1,382	7	
8													8	
9	TOTAL Facility Related						\$	15,801,537				\$	1,028,225	9
	B. Non-Facility Related*													
10	Interest Income		X									(16,593)	10	
11	Interest Income - Bldg Co.		X									(7,726)	11	
12													12	
13	Allocated from CF St. Louis	X										1,574	13	
14	TOTAL Non-Facility Related						\$					\$	(22,745)	14
15	TOTALS (line 9+line14)						\$	15,801,537				\$	1,005,480	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	96,255	Line #	36
---	-----------	---------------	---------------	-----------

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	897,880	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.)				\$	995,914	2
3. Under or (over) accrual (line 2 minus line 1).				\$	98,034	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	855,521	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				\$		6
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.				\$	953,555	7
Assessed Value from Real Estate Tax Bill:	2024	2,865,016	8			
Real Estate Tax Bill for Calendar Year:	2020	802,551	9			
	2021	823,998	10			
	2022	837,333	11			
	2023	994,048	12			
	2024	994,048	13			
2025 Accrual = \$897,880 x 0.95282= \$855,521 (rounded)						
Allocated from CF St. Louis: \$1,866						

FOR BHF USE ONLY			
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bella Terra Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055962

CONTACT PERSON REGARDING THIS REPORT John Epperson

TELEPHONE (312) 344-2883 FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 03-10-401-027-0000	Long Term Care Property	\$ 994,047.68	\$ 994,047.68
2. 10-23-406-034-0000	Home Office Allocation	\$ 758,833.99	\$ 1,866.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,752,881.67	\$ 995,913.68

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

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.

☐

(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).

None.

F. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility,

IDPH license number of this related party and the date the present owners took over.

N/A

K. 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		2019	\$ 1,670,000	1
2	Allocated from CF St. Lous LLC			1,598	2
3	TOTALS			\$ 1,671,598	3

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	214		2019	1995	\$ 5,151,141	\$ 133,204	40	\$ 128,779	\$ (4,425)	\$ 901,450
5										
6										
7										
8										
	Improvement Type**									
9	Various		2019		176,675		20	8,834	8,834	61,836
10	Various		2020		64,221		20	3,211	3,211	19,266
11	Various		2021		55,011		20	2,751	2,751	13,753
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$5,447,048	\$133,204		\$143,574	\$10,370	\$996,305	70

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

Facility Name & ID Number Bella Terra Wheeling

0055962

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,447,048	\$ 133,204		\$ 143,574	\$ 10,370	\$ 996,305	1
2	Current Year Depreciation			33,442	20		(33,442)		2
3	Replace 2 Fire Door In Basement & 8 Rooftop Exhaust Motors (\$3,147)	2022	3,147		20	157	157	628	3
4	Pump #2 - Replace Rubber Mission Bands, Pump #1 - Replace Val	2022	8,057		20	403	403	1,612	4
5	Installation Of Backflow Assembly (\$3,039)	2022	2,957		20	148	148	592	5
6	Repaint Cabinets In Linen Storage Room (\$3,950)	2022	3,843		20	192	192	768	6
7	Supply And Install Fiberglass Pipe Insulation On Cold Pipes (\$7,9	2022	7,782		20	389	389	1,556	7
8	Install New Motors On 6 Fire Dampers (\$4,644)	2022	4,537		20	227	227	908	8
9	Furnish And Install New Jack Assembly For Elevator (\$68,445)	2022	66,590		20	3,330	3,330	13,320	9
10	Wall Rack,Setup Cables, Distribute & Connect Equipment (\$4,385	2022	4,266		20	213	213	852	10
11	Wall Rack,Setup Cables, Distribute & Connect Equipment (\$18,31	2022	17,815		20	891	891	3,564	11
12	Hvac Units In Rms 326,331 - New Motors (\$3,145)	2022	3,060		20	153	153	612	12
13	Pipe Repairs - New Supply To Inlet & Outlet Of In-Line Filters (\$	2022	2,851		20	143	143	572	13
14	Replace Damper Actuator On 1St Floor (\$2,862)	2022	2,785		20	139	139	556	14
15	Elevator Repair - Dig Out Hole For Jack Replacement (\$19,620)	2023	19,088		20	954	954	2,862	15
16	Install 2 Grease Interceptors On Triple Compartment Sink/Rerou	2023	10,970		20	549	549	1,647	16
17	Install New Underground Drain Pipe For Bathrooms (\$4,580)	2023	4,456		20	223	223	669	17
18	Installation Of 2 New Maglocks For 2 Doors (\$6,380)	2023	6,207		20	310	310	930	18
19	Repair Locks On 2 Fire Doors,Replace Motors On 2 Roof Top Exl	2023	2,539		20	127	127	381	19
20	Concrete Repairs - Patio, Sidewalk, Square (\$7,650)	2023	7,443		20	372	372	1,116	20
21	Parking Lot Asphalt Repairs And Sealing And Striping (\$12,650)	2023	12,238		20	612	612	1,836	21
22	Replace Nurse Call System On 2Nd Floor (\$20,140)	2023	19,594		20	980	980	2,940	22
23	Shower Area (5 Showers) - Install Plumbing Fixtures,Tile,Shower	2023	36,519		20	1,826	1,826	5,478	23
24	Replace Wander Guard For Basement Exit Door Ramp (\$2,524)	2023	2,442		20	122	122	366	24
25	Install Dining Room Wall Panels And Paint Dining Room (\$11,350)	2023	10,980		20	549	549	1,647	25
26	Wall Rack, Setup Cat5 Cable, 3Cx System Setup,Remote Support	2023	5,863		20	293	293	879	26
27	Phone System Setup - Run Cat5 Cable (\$2,630)	2023	2,559		20	128	128	384	27
28	Boiler Number 4 Repair - Install New Pump (\$4,289)	2023	4,172		20	209	209	627	28
29	Boiler #1 And 2 Repairs - Replace Flow Switch And Pump Motor	2023	3,255		20	163	163	489	29
30	Nursecall System Repair - Pull New Wire To Separate Wings (\$4,1	2023	4,024		20	201	201	603	30
31	Repair Roof Where Water Leaks Into Building (\$5,275)	2023	5,132		20	257	257	771	31
32	Replace Cracked 1St Flr Therapy Rm Sprinkler Pipe (\$2,650)	2023	2,578		20	129	129	387	32
33	Replace Transformer,Spark Module,Relay On Boiler #1 (\$2,677)	2023	2,590		20	130	130	390	33
34	TOTAL (lines 1 thru 33)		\$ 5,737,387	\$ 166,646		\$ 158,093	\$ (8,553)	\$ 1,046,247	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,737,387	\$ 166,646		\$ 158,093	\$ (8,553)	\$ 1,046,247	1
2	Kitchen Tile (\$4,500)	2024	2,590		20	130	130	260	2
3	Kitchen Patching, Painting and Tile replacement (\$12,700)	2024	4,500		20	225	225	450	3
4	Storm System Pump and Elevator Pump (\$4,166)	2024	12,700		20	635	635	1,270	4
5	Parking Pole Lights (\$5,511)	2024	4,166		20	208	208	416	5
6	Removal and Replacing of Fencing (\$2,580)	2024	5,510		20	276	276	552	6
7	Current Year Depreciation - Improvements	2024	2,580		20	129	129	258	7
8	Kitchen Tile	2025	4,496		20	225	225	225	8
9	Remodel shower	2025	8,995		20	450	450	450	9
10	Parking Pole Lights	2025	4,895		20	245	245	245	10
11	Air separator tank replacement	2025	12,431		20	622	622	622	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,800,250	\$ 166,646		\$ 161,238	\$ (5,408)	\$ 1,050,995	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,800,250	\$ 166,646		\$ 161,238	\$ (5,408)	\$ 1,050,995	1
2									2
3	Related Party								3
4	Buildings:								4
5	Allocated from CF St. Louis, LLC	2016	8,606	170	35	246	76	2,459	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from CF St. Louis, LLC	2016	119,282	820	20	5,964	5,144	59,641	9
10	Allocated from CF St. Louis, LLC	2017	2,769	71	20	138	67	1,246	10
11	Allocated from CF St. Louis, LLC	2019	25,094	644	20	1,255	611	8,783	11
12	Allocated from CF St. Louis, LLC	2020	1,320	34	20	66	32	396	12
13	Allocated from CF St. Louis, LLC	2021	4,686	120	20	234	114	1,171	13
14	Allocated from CF St. Louis, LLC	2022	7,746	199	20	387	188	1,549	14
15	Allocated from CF St. Louis, LLC	2023	1,080	28	20	54	26	162	15
16									16
17	Allocated from Legacy HC	2018	143		20	7	7	57	17
18	Allocated from Legacy HC	2020	108		20	5	5	32	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,971,084	\$ 168,732		\$ 169,595	\$ 863	\$ 1,126,491	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	\$ 1,109,803	\$ 93,286	\$ 110,980	\$ 17,694		\$ 114,946	71
72	Current Year Purchases	50,880	3,038	5,088	2,050		5,088	72
73	Fully Depreciated Assets	107,485					107,485	73
74								74
75	TOTALS	\$ 1,268,168	\$ 96,324	\$ 116,068	\$ 19,744		\$ 227,519	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	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)	\$ 8,910,850	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 265,056	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,664	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,608	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,354,010	85

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

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

G. Construction-in-Progress

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

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

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

Bella Terra Wheeling
0055962
Moveable Equipment Schedule
1/1/2025
12/31/2025

Company Name	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Accumulated Straight Line Depreciation
Line 28: Prior Years					
Bella Terra Wheeling	398,924	92,884	39,892	(52,992)	39,892
Wheeling Property Holdings, LLC	703,000	-	70,300	70,300	70,300
Allocated from Legacy HC	60	-	6	6	18
Allocated from CF St. Louis, LLC	7,819	402	782	380	4,736
Total	1,109,803	93,286	110,980	17,694	114,946

Line 29: Current Year

Bella Terra Wheeling	50,880	3,038	5,088	2,050	5,088
Wheeling Property Holdings, LLC	-	-	-	-	
Allocated from Legacy HC	-	-	-	-	-
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	50,880	3,038	5,088	2,050	5,088

Line 30: Fully Depreciated

Bella Terra Wheeling	102,694	-	-	-	102,694
Wheeling Property Holdings, LLC	-	-	-	-	-
Allocated from Legacy HC	4,791	-	-	-	4,791
Allocated from CF St. Louis, LLC	-	-	-	-	-
Total	107,485	-	-	-	107,485

Total (Should tie to page 13)

Bella Terra Wheeling	552,498	95,922	44,980	(50,942)	147,674
Wheeling Property Holdings, LLC	703,000	-	70,300	70,300	70,300
Allocated from Legacy HC	4,851	-	6	6	4,809
Allocated from CF St. Louis, LLC	7,819	402	782	380	4,736
Total	1,268,168	96,324	116,068	19,744	227,519

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Legacy HC				20,070			5
6								6
7	TOTAL				\$ 20,070			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: \$ 13,891 Description: See Supplemental Schedule Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Legacy HC		\$	\$ 1,641	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,641	21

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

Supplemental Schedule of Equipment Rental		12/31/2025
	Description	Amount
16A	Copiers	8,201
16B	Air Fresheners	5,460
16C	Allocation from Legacy HC	230
16D		
16E		
16F		
16G		
16 H		
16I		
16J		
		13,891

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 3	hrs	\$		\$ 245,524	\$		\$ 245,524	1
2	Licensed Speech and Language Development Therapist	39 - 3	hrs			101,485			101,485	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 3	hrs			343,460			343,460	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				267,730		267,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	See Attached				176,389	198,932		375,321	13
14	TOTAL			\$		\$ 866,858	\$ 466,662		\$ 1,333,520	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.

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

Special Services - Supplies (Column 6 - Other)		Amount	Special Services - Salary (Column 3 - Staff)		Amount
13A	Supplies - Medical	39-2	174,741	13U	
13B	Supplies - G-Tube	39-2	10,746	13V	
13C	Oxygen	39-2	13,445	13W	
13D				13X	
13E				13Y	
13F				13Z	
13G					
13 H					
13I					
13J					
			198,932		
Special Services - Outside (Column 5 - Other)					
13K	Durable Medical Equipment	39-3	106,738		
13L	Oxygen Equipment Rental	39-3	2,845		
13M	Radiology	39-3	8,775		
13N	Laboratory	39-3	13,224		
13O	Rehabilitation	39-3	44,807		
13P					
13Q					
13R					
13S					
13T					
			#####		

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,339,776	\$ 1,951,420	1
2	Cash-Patient Deposits	60	60	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,530,657	1,532,290	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,670	1,670	6
7	Other Prepaid Expenses	1,785	1,785	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached</u>	341,575	2,255,902	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,215,523	\$ 5,743,127	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,730	1,675,730	13
14	Buildings, at Historical Cost		5,151,140	14
15	Leasehold Improvements, at Historical Cost	431,819	474,984	15
16	Equipment, at Historical Cost	603,377	1,306,377	16
17	Accumulated Depreciation (book methods)	(496,993)	(2,037,350)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See attached</u>	4,082,909	13,444,942	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,626,842	\$ 20,015,823	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,842,365	\$ 25,758,950	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 910,222	\$ 910,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,063,271	1,063,271	29
30	Accrued Salaries Payable	855,932	855,932	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,531	34,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)		855,521	32
33	Accrued Interest Payable		72,218	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached</u>	572,617	1,083,716	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,436,573	\$ 4,875,411	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		(14,738,266)	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See attached</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ (14,738,266)	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,436,573	\$ (9,862,855)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,405,792	\$ 35,621,805	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,842,365	\$ 25,758,950	48

*(See instructions.)

Facility Name & ID Number		Bella Terra Wheeling		STATE OF ILLINOIS		Page 17 - SUPP	
		# 0055962		Report Period Beginning:		01/01/2025 Ending: 12/31/2025	
Supplemental Schedule Of Other Assets And Liabilities				As of 12/31/2025			
	Other Current Assets	Amount	Amount		Other Current Liabilities	Amount	Amount
09A	Refund	55,895.00	55,895.00	36A	Prepaid - Legal Fees	-	-
09B	Exchange	(18,092.00)	(18,092.00)	36B	Payroll Exchange	-	-
09C	Insurance Refund Exchange	(27,127.00)	(27,127.00)	36C	Accrued Rent	437,699.00	437,699.00
09D	Accounts Receivable - Quality Incentive	(873,516.00)	(873,516.00)	36D	Accrued Accounting Fees	14,027.00	14,027.00
09E	C.N.A. Tenure Program	1,202,661.00	1,202,661.00	36E	Accrued Monthly Assessment Fee	153,624.00	153,624.00
09F	Employee Loans	-	-	36F	Union Dues Payable	(4,924.00)	(4,924.00)
09G	Security Deposit	1,754.00	1,754.00	36G	Due To/From Medicare	(27,809.00)	(27,809.00)
09H	Bad Debt Part A - MMAI	-	-	36H	Replacement Reserve Escrow - Tenant		412,519.00
09I	Replacement Reserve Escrow - HUD		467,839.00	36I	Insurance Escrow - Tenant		14,546.00
09J	See next page		1,446,488.00	36J	MIP Escrow - Tenant		84,034.00
		-	2,255,902			572,617	1,083,716
	Other Non-Current Assets:	Amount	Amount		Other Non-Current Liabilities	Amount	Amount
23A	Escrow - R&R	265,260.00	265,260.00	43A	Right Of Use Lease Liability	-	-
23B	Right Of Use Asset	-	-	43B			
23C	Due To/From - Bella Terra Wheeling & Management Co	902,151.00	902,151.00	43C			
23D	Due To/From - Bella Terra Wheeling & Bella Terra S	2,410,987.00	2,410,987.00	43D			
23E	Due To/From Propco	190,085.00	190,085.00	43E			
23F	Due To/From Prior Owner	63,946.00	63,946.00	43F			
23G	Due To/From Others	250,338.00	250,338.00	43G			
23H	Accrued Management Fees Entities	142.00	142.00	43H			
23I	Due To/From		9,059,497.00	43I			
23J	See next page		302,536.00	43J			
		-	13,444,942.00			-	-

	Other Current Assets	Amount	Amount		Other Current Liabilities	Amount	Amount
09A	Tax Escrow - HUD		310,963.00	36A			
09B	Insurance Escrow - HUD		18,265.00	36B			
09C	MIP Escrow - HUD		96,255.00	36C			
09D	Escrow Other - HUD		571,022.00	36D			
09E	Deferred Rent Receivable		144,412.00	36E			
09F	Accrued R/E Tax Reimb		305,571.00	36F			
09G				36G			
09H				36H			
09I				36I			
09J				36J			
		-	1,446,488			-	-
	Other Non-Current Assets:	Amount	Amount		Other Non-Current Liabilities	Amount	Amount
23A	Due To/From Opco		84,490.00	43A			
23B	Financing Fees		129,450.00	43B			
23C	Goodwill		790,860.00	43C			
23D	A/A Financing Fee		(11,404.00)	43D			
23E	A/A - Goodwill		(690,860.00)	43E			
23F				43F			
23G				43G			
23H				43H			
23I				43I			
23J				43J			
		-	302,536.00			-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,647,594	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,647,594	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	770,604	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	(12,406)	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)	\$ 758,198	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)	\$ 4,405,792	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bella Terra Wheeling

0055962

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 24,738,690	1
2	Discounts and Allowances for all Levels	(7,257,910)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,480,780	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,760,548	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,760,548	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	279,492	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,040	20
21	Other Medical Services	66,682	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 353,214	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,593	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,593	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Quality Incentive</u>	647,977	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 647,977	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,259,112	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,969,499	31
32	Health Care	8,390,143	32
33	General Administration	3,313,626	33
	B. Capital Expense		
34	Ownership	2,474,775	34
	C. Ancillary Expense		
35	Special Cost Centers	2,358,846	35
36	Provider Participation Fee	981,619	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,488,508	40
41	Income before Income Taxes (line 30 minus line 40)**	770,604	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 770,604	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 5,742,016.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,053,428.00	45
46	MMAI-Medicaid is the Primary Payer	2,329,764.00	46
47	MMAI-Medicare is the Primary Payer	12,643.00	47
48	Private Pay	2,409,683.00	48
49	Medicare Part A	801,751.00	49
50	Other-(specify) <u>Insurance</u>	131,495.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 17,480,780	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,904	2,119	\$ 162,358	\$ 76.62	1
2	Assistant Director of Nursing	1,888	2,120	125,617	59.25	2
3	Registered Nurses	34,985	44,765	2,289,267	51.14	3
4	Licensed Practical Nurses	28,081	33,551	1,396,187	41.61	4
5	CNAs & Orderlies	80,475	97,568	2,513,003	25.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,385	9,650	320,650	33.23	8
9	Activity Director	2,401	2,497	66,339	26.57	9
10	Activity Assistants	7,286	7,946	157,595	19.83	10
11	Social Service Workers	3,813	4,200	142,393	33.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,080	84,526	40.64	17
18	Housekeepers	30,412	34,681	748,828	21.59	18
19	Laundry	9,045	10,802	241,747	22.38	19
20	Administrator	1,928	2,080	207,682	99.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,656	1,895	50,452	26.62	23
24	Clerical	10,987	12,309	422,102	34.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,872	2,042	52,531	25.73	31
32	Other Health C: Transportation Co	1,444	1,739	41,993	24.15	32
33	Other(specify)			0		33
34	TOTAL (lines 1 - 33)	227,514	272,044	\$ 9,023,270 *	\$ 33.17	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,212,164	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	17,646	10-03	38
39	Pharmacist Consultant	Monthly	28,076	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,265	11-03	44
45	Social Service Consultant	Monthly	7,061	12-03	45
46	Other(specify) Psychiatric Consultant		50	09-03	46
47	Payroll Consultant	Monthly	34,712	19-03	47
48	Purchasing Consultant	Monthly	11,600	19-03	48
49	TOTAL (lines 35 - 48)		\$ 1,345,574		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,841	\$ 321,933	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	21,806	534,844	10-03	52
53	TOTAL (lines 50 - 52)	27,647	\$ 856,777		53

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

** See instructions.

Facility Name & ID Number		Bella Terra Wheeling		STATE OF ILLINOIS		Report Period Beginning:		01/01/2025		Page 21		
				# 0055962				Ending:		12/31/2025		
XIX. SUPPORT SCHEDULES												
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
Michael Florczak		Administrator	0	\$ 207,682	Workers' Compensation Insurance		\$ 68,931	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		34,818	Advertising: Employee Recruitment				
					FICA Taxes		673,634	Health Care Worker Background Check				
					Employee Health Insurance		183,582	(Indicate # of checks performed 57)		573		
					Employee Meals			Patient Background Checks		354 3,540		
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		15,957		
					401K Expense		38,854	Other Dues & Subscriptions		31,717		
					Union Pension		46,509	Licenses & Permits		3,224		
					Employee Benefits		50,186					
					Voluntary Benefit Contribution		13,851	Allocation from Legacy Healthcare Financial		2,098		
					Employee Physical Exams		8,139	Less: Public Relations Expense (				
					Employee Tuition & Exam fees			PAC and Lobbying payments		(7,979)		
					Other Employee Benefits			All non-allowable advertising (				
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,118,504	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 51,121		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 207,682	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
B. Administrative - Other					Description		Line #	Amount	Description		Amount	
									Out-of-State Travel		\$	
									In-State Travel			
									Seminar Expense		2,046	
									Allocation from Legacy Healthcare Financial		1,058	
									Entertainment Expense (			
									(agree to Sch. V, line 24, col. 8)			
					TOTAL		\$		TOTAL		\$ 3,104	

Bella Terra Wheeling
0055962
Legal Schedule
01/01/2025 - 12/31/2025

Date	G/L Account No.	Payee/Vendor	Type of Service Provided	Amount	Adjustment	Adjusted Amount
9/25/2024	580063	Monahan Law Group, LLC	General Counsel	2,160	-	2,160.00
1/27/2025	580063	Meyer Magence	General Counsel	175	-	175.00
1/17/2025	580063	Ellen E. Douglass	General Counsel	2,985	-	2,985.00
1/23/2025	580063	Law Office of Damon Doucet	General Counsel	1,381	-	1,381.00
1/24/2025	580063	Skidelsky & Associates	Real Estate Tax Assessment	400	400	-
1/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,181	1,181	-
2/21/2025	580063	Meyer Magence	General Counsel	438	-	437.50
2/8/2025	580063	Corporation Service Company	Statutory Representation	104	-	103.62
2/28/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,139	1,139	-
3/25/2025	580063	Meyer Magence	General Counsel	175	-	175.00
3/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,476	1,476	-
4/11/2025	580063	Meyer Magence	General Counsel	263	-	262.50
4/11/2025	580063	Corporation Service Company	Matter Management	198	-	197.64
4/23/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	48	-	47.81
4/30/2025	580063	Forbright	RLOC fee	250	250	-
4/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	450	450	-
5/5/2025	580063	Monahan law group, llc	General Counsel	(160)	-	(160.00)
5/9/2025	580063	CLIA Laboratory	Certificate Fee	248	248	-
5/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,154	1,154	-
6/4/2025	580063	Meyer Magence	General Counsel	88	-	87.50
6/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,271	1,271	-
7/23/2025	580063	Meyer Magence	General Counsel	88	-	87.50
7/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	722	722	-
8/18/2025	580063	Walker and Dunlop, LLC Corporate Ac	HUD Fees	15,000	15,000	-
8/18/2025	580063	Walker and Dunlop, LLC Corporate Ac	HUD Fees - reimbursement	(7,500)	(7,500)	-
8/26/2025	580063	Meyer Magence	General Counsel	175	-	175.00
8/25/2025	580063	Law Hesselbaum	General Counsel	85	-	85.00
8/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	1,111	1,111	-
8/31/2025	580063	Forbright	RLOC monitoring fee	3,371	3,371	-
9/27/2024	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	(122)		(122.22)
9/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	363	363	-
9/30/2025	580063	Forbright	RLOC retainage	955	955	-
10/21/2025	580063	Meyer Magence	General Counsel	88	-	87.50
10/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	991	991	-
10/31/2025	580063	Forbright	RLOC draws	423	423	-
11/20/2025	580063	Forbright	RLOC draws	257	257	-
11/21/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	38	-	38.00
11/30/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	2,301	2,301	-
12/17/2025	580063	Neal, Gerber, & Eisenberg LLP	General Counsel	90	-	90.00
12/31/2025	580063	Stone Pogrund & Korey LLC	Collections and Guardianship	830	830	-
12/31/2025	580063	Forbright	RLOC draws	431	431	-
						-
						-
						-
Total				35,117	26,824	8,293

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>7,979</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>7,979</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>7,979</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>7,979</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>15,957</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>15,957</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 70,299 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 981,619
This amount is to be recorded on line 42 of Schedule V.
- (8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% LN1
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.