

FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0052514</u></p> <p>Facility Name: <u>Park Place of Belvidere</u></p> <p>Address: <u>1701 5th Avenue</u> <u>Belvidere</u> <u>61008</u> Number City Zip Code</p> <p>County: <u>Boone</u></p> <p>Telephone Number: <u>815-547-5451</u> Fax # <u>815-544-4509</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>8/26/13</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David Shamsi</u> Telephone Number: <u>847-983-4860</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other _____	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td align="right">(Date) <u>4/26/2021</u></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Aaron Topper</u></td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> </tr> <tr> <td style="border-top: 1px solid black;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____		(Date) <u>4/26/2021</u>		(Type or Print Name) <u>Aaron Topper</u>		(Title) <u>CEO</u>	Paid Preparer	(Signed) _____		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																									
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Paid Preparer	(Signed) _____																																										
	(Date) _____																																										
	(Print Name and Title) _____																																										
	(Firm Name & Address) _____																																										
	(Telephone) <u>()</u> Fax # <u>()</u>																																										

Facility Name & ID Number Park Place of Belvidere

0052514 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	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	31	Skilled (SNF)	31	11,346	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,011	222	5,086	8,319	8
9	SNF/PED					9
10	ICF	11,459	58		11,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,470	280	5,086	19,836	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.75%

D. How many bed reserve days during this year were paid by the Department?
0 (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 08/26/13

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/26/13 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 2,794

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Park Place of Belvidere # 0052514 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	204,850	12,049	23,957	240,856		240,856		240,856		1
2	Food Purchase		109,361		109,361		109,361		109,361		2
3	Housekeeping	123,657	20,977	5,822	150,456		150,456		150,456		3
4	Laundry		10,647		10,647		10,647		10,647		4
5	Heat and Other Utilities			57,850	57,850		57,850		57,850		5
6	Maintenance	41,747	17,118	31,065	89,930		89,930		89,930		6
7	Other (specify):*										7
8	TOTAL General Services	370,254	170,152	118,694	659,100		659,100		659,100		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,252,254	230,480	103,457	1,586,191		1,586,191		1,586,191		10
10a	Therapy		228	324,877	325,105		325,105		325,105		10a
11	Activities	57,152	731	3,173	61,056		61,056		61,056		11
12	Social Services	35,762		120	35,882		35,882		35,882		12
13	CNA Training										13
14	Program Transportation			18,768	18,768		18,768		18,768		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,345,168	231,439	450,395	2,027,002		2,027,002		2,027,002		16
	C. General Administration										
17	Administrative	90,392		268,810	359,202		359,202		359,202		17
18	Directors Fees										18
19	Professional Services			22,821	22,821		22,821		22,821		19
20	Dues, Fees, Subscriptions & Promotions			14,059	14,059		14,059		14,059		20
21	Clerical & General Office Expenses	41,132		203,587	244,719		244,719	(19,706)	225,013		21
22	Employee Benefits & Payroll Taxes			288,380	288,380		288,380		288,380		22
23	Inservice Training & Education										23
24	Travel and Seminar			425	425		425	(100)	325		24
25	Other Admin. Staff Transportation							(1,000)	(1,000)		25
26	Insurance-Prop.Liab.Malpractice			65,826	65,826		65,826		65,826		26
27	Other (specify):*										27
28	TOTAL General Administration	131,524		863,908	995,432		995,432	(20,806)	974,626		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,846,946	401,591	1,432,997	3,681,534		3,681,534	(20,806)	3,660,728		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			40,619	40,619		40,619	15,803	56,422		30
31	Amortization of Pre-Op. & Org.			27,103	27,103		27,103		27,103		31
32	Interest							125,178	125,178		32
33	Real Estate Taxes							36,250	36,250		33
34	Rent-Facility & Grounds			292,727	292,727		292,727	(292,727)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*							(68,946)	(68,946)		36
37	TOTAL Ownership			360,449	360,449		360,449	(184,442)	176,007		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			116,420	116,420		116,420		116,420		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			116,420	116,420		116,420		116,420		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,846,946	401,591	1,909,866	4,158,403		4,158,403	(205,248)	3,953,155		45

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

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,106)	30		9
10	Interest and Other Investment Income	(87)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,000)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,754)	21		18
19	Entertainment	(100)	24		19
20	Contributions	(18,100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,946)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (97,093)		\$	30

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	2	
		Amount	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)	(108,155)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (108,155)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (205,248)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Park Place of Belvidere

ID# 0052514

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(19,854)	148	0	0	0	0	0	0	0	0	0	(19,706)	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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	24
25	Other Admin. Staff Transportation	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,954)	148	0	0	0	0	0	0	0	0	0	(20,806)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,954)	148	0	0	0	0	0	0	0	0	0	(20,806)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(7,106)	22,909	0	0	0	0	0	0	0	0	0	15,803	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(87)	125,265	0	0	0	0	0	0	0	0	0	125,178	32
33	Real Estate Taxes	0	36,250	0	0	0	0	0	0	0	0	0	36,250	33
34	Rent-Facility & Grounds	0	(292,727)	0	0	0	0	0	0	0	0	0	(292,727)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(68,946)	0	0	0	0	0	0	0	0	0	0	(68,946)	36
37	TOTAL Ownership	(76,139)	(108,303)	0	0	0	0	0	0	0	0	0	(184,442)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(97,093)	(108,155)	0	0	0	0	0	0	0	0	0	(205,248)	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
Aaron Topper	47	Pavilion of Waukegan	Waukegan	Belvidere Care Center	Belvidere	Bldg Rental
Joseph Brandman	47	Crossroads Care Center of Woodstock	Woodstock			
Joseph Topper	4					
Marlee Associates	2					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 292,727	Belvidere Care Center	100.00%	\$	\$ (292,727)	1
2	V	32 Interest		Belvidere Care Center		125,265	125,265	2
3	V	33 Real Estate Tax		Belvidere Care Center		36,250	36,250	3
4	V	30 Depreciation		Belvidere Care Center		22,909	22,909	4
5	V	21 Bank Fees		Belvidere Care Center		148	148	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 292,727			\$ 184,572	\$ * (108,155)	14

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

Facility Name & ID Number

Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Topper	Manager	Mgmt	0.47	698,888	10	20.00	Mgmt Fees	\$ 235,405	17-3	1
2	Joseph Brandman	Manager	Mgmt	0.47	57,365			Mgmt Fees	33,405	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 268,810		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

Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Fifth Third Bank		x	Mortgage	\$19,426.00	4/15/2020	\$ 3,464,907	\$ 2,402,918	4/15/21	3.7500	\$ 78,542	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$19,426.00		\$ 3,464,907	\$ 2,402,918			\$ 78,542	9								
B. Non-Facility Related*																				
10	Interest Income										87	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 87	14								
15	TOTALS (line 9+line14)						\$ 3,464,907	\$ 2,402,918			\$ 78,629	15								

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

* 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

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

1. Real Estate Tax accrual used on 2019 report.		\$	35,103	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.)		\$	36,250	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,147	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	35,103	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. 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.		\$	36,250	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	34,977	8
	2016	34,001	9
	2017	33,152	10
	2018	33,849	11
	2019	35,103	12

FOR BHF USE ONLY

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place of Belvidere COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0052514

CONTACT PERSON REGARDING THIS REPORT Aaron Topper

TELEPHONE 847-983-4860 FAX #: 847-673-3379

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-35-409-010</u>	<u>Facility</u>	\$ <u>35,102.94</u>	\$ <u>35,102.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>35,102.94</u></u>	\$ <u><u>35,102.94</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Park Place of Belvidere

0052514 Report Period Beginning:

01/01/2020 Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,636 B. General Construction Type: Exterior Brick Frame Brick Number of Stories _____

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).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	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	80	2013		\$ 630,000	\$ 20,950	27.5	\$ 20,950	\$	\$ 148,520	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sprinkler System	2014		5,867	210	27.5	213	3	1,429	9
10	Roof	2014		5,000	178	27.5	182	4	1,100	10
11	Replace Broken Sprinklers	2015		20,983	2,090	15	1,399	(691)	7,694	11
12	Door Push Button	2015		941	94	15	65	(29)	351	12
13	Kitchen Exhaust Hood Project	2015		24,080	7,030	15	1,606	(5,424)	8,833	13
14	Replace Gutters	2015		2,809	281	15	187	(94)	1,029	14
15	Replace Ramp	2016		3,665	366	15	244	(122)	1,220	15
16	Replace Water Heater	2016		21,260	2,714	15	1,417	(1,297)	7,086	16
17	Sprinkler Work	2016		1,735	174	15	116	(58)	580	17
18	Install New Circuit	2016		2,209	221	15	147	(74)	735	18
19	Additions 2017									19
20	Sprinkler	2017		6,742	674	15	450	(224)	2,005	20
21	LED Lighting	2017		17,993	1,799	15	1,200	(599)	5,347	21
22	Central Air	2017		6,127	613	15	408	(205)	1,820	22
23	Replace Copper Pipes-Laundry Room	2018		3,823	382	15	255	(127)	701	23
24	New Garbage Disposal in Kitchen	2018		3,057	306	15	204	(102)	561	24
25	Johnson Controls	2019		3,121	312	15	208	(104)	416	25
26	Boiler Valves	2019		2,480	248	15	165	(83)	330	26
27	Freezer	2020		3,064	153	10	153		153	27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 764,956	\$ 38,795		\$ 29,569	\$ (9,226)	\$ 189,910	70

**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	\$ 170,276	\$ 51,954	\$ 26,331	\$ (25,623)	5	\$ 171,297	71
72	Current Year Purchases	5,964	522	522		5	522	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 176,240	\$ 52,476	\$ 26,853	\$ (25,623)		\$ 171,819	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 991,196	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,271	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,422	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (34,849)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 361,729	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,383,092	\$ 2,367,551	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 69,918)	1,280,867	1,280,867	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,862	21,862	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,161	3,161	8
9	Other(specify): various/related homes/escrows	34,648	2,814,758	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,724,130	\$ 6,488,699	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		630,000	14
15	Leasehold Improvements, at Historical Cost	134,793	134,793	15
16	Equipment, at Historical Cost	176,240	176,240	16
17	Accumulated Depreciation (book methods)	(232,104)	(888,228)	17
18	Deferred Charges	3,400	3,400	18
19	Organization & Pre-Operating Costs	7,690	236,381	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,391)	(29,391)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,628	\$ 313,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,784,758	\$ 6,801,894	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 290,675	\$ 290,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,112	99,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,791	41,791	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,857	32
33	Accrued Interest Payable		5,975	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Accrued expenses	495,262	495,262	36
37	Other	545,352	545,352	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,472,192	\$ 1,517,024	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,371,574	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,371,574	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,472,192	\$ 4,888,598	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,312,566	\$ 1,947,944	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,784,758	\$ 6,836,542	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (509,792)	1
2	Restatements (describe):		2
3	Balance sheet reconciliation	767,919	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 258,127	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,349,439	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	(295,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,054,439	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)	\$ 1,312,566	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Place of Belvidere# 0052514Report Period Beginning: 01/01/2020Ending: 12/31/2020**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,507,755	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,507,755	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	87	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 87	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,507,842	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	659,100	31
32	Health Care	2,027,002	32
33	General Administration	1,013,341	33
B. Capital Expense			
34	Ownership	342,540	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	116,420	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,158,403	40
41	Income before Income Taxes (line 30 minus line 40)**	1,349,439	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,349,439	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,718,367	44
45	Private Pay - Net Inpatient Revenue	35,845	45
46	Medicare - Net Inpatient Revenue	1,747,138	46
47	Other-(specify) <u>Cares Act</u>	715,383	47
48	Other-(specify) <u>Various</u>	291,022	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,507,755	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Park Place of Belvidere

0052514

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,793	1,968	\$ 97,894	\$ 49.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,981	14,858	509,793	34.31	3
4	Licensed Practical Nurses	4,253	4,399	136,646	31.06	4
5	CNAs & Orderlies	30,485	31,803	496,207	15.60	5
6	CNA Trainees	849	849	11,714	13.80	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,933	2,135	39,231	18.38	9
10	Activity Assistants	1,645	1,645	17,921	10.89	10
11	Social Service Workers	1,968	2,080	35,762	17.19	11
12	Dietician	16,794	17,558	204,850	11.67	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,687	1,935	41,747	21.57	17
18	Housekeepers	10,874	11,351	123,657	10.89	18
19	Laundry					19
20	Administrator	1,992	2,120	90,392	42.64	20
21	Assistant Administrator					21
22	Other Administrative	2,798	2,798	41,132	14.70	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,052	95,499	\$ 1,846,946 *	\$ 19.34	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 7,956		35
36	Medical Director	8,000		36
37	Medical Records Consultant	1,668		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,296		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	731		44
45	Social Service Consultant			45
46	Other(specify) <u>Cardiac</u>	10,000		46
47	<u>Therapy</u>	634		47
48	<u>Reimbursement</u>	5,250		48
49	TOTAL (lines 35 - 48)	\$ 36,535		49

C. CONTRACT NURSES

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

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		
Margaret Ryan	Administrator	0	\$ 90,392	Workers' Compensation Insurance	\$ 58,434	IDPH License Fee	\$		
				Unemployment Compensation Insurance	8,368	Advertising: Employee Recruitment	7,136		
				FICA Taxes	139,917	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	64,899	Patient Background Checks	560		
				Employee Meals		Healthcare Council of IL	3,600		
				Illinois Municipal Retirement Fund (IMRF)* 401K match	16,762	Various	2,763		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,392						
B. Administrative - Other									
Description			Amount						
Aaron Topper - Mgmt Fees			\$ 235,405				Less: Public Relations Expense ()		
Joseph Brandman - Mgmt Fees			33,405				Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 268,810	TOTAL (agree to Schedule V, line 22, col.8)			\$ 288,380	TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mendel S. Schneider & Associates	Accounting		\$ 8,000				Out-of-State Travel	\$	
Franks Gerkin McKenna	Legal		2,921						
Quarles & Brady LLP	Legal		206				In-State Travel	425	
Rolf	Legal		657						
Sher, LLP	Legal		849				Seminar Expense		
The Law Office of Daniel G. Parson	Legal		894						
Align Executive Search	Recruiting		4,534				Entertainment Expense	(100)	
CertiSurv,LLC	Management		760				(agree to Sch. V, line 24, col. 8)		
Nova Healthcare Solutions	Management		3,400				TOTAL	\$ 325	
Prospect Resources	Management		600						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 22,821	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Place of Belvidere# 0052514Report Period Beginning: 01/01/2020Ending: 12/31/2020**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Health Care Council of Illinois-1,400
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,143 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 116,420
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? _____ For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.