

		FOR BHF USE					

LL1

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2020)

IMPORTANT NOTICE

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

I.

IDPH License ID Number:

0054809

Facility Name:

Landmark Des Plaines Rehab

Address:

9300 Ballard Road

Des Plaines

60016

Number

City

Zip Code

County:

Cook

Telephone Number:

708-449-1900

Fax #

708-449-1500

HFS ID Number:

Date of Initial License for Current Owners:

12/01/17

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name:

Aaron Mauer

Telephone Number:

773-747-4506

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

1/1/20

to

12/31/20

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)

3/18/2021

(Date)

(Type or Print Name)

Paresh Vipani

(Title)

CFO

Paid Preparer

(Signed)

3/18/2021

(Date)

(Print Name and Title)

Aaron Mauer President

(Firm Name & Address)

GGM Associates, Inc. 6101 Nimtz Parkway South Bend IN 46628

(Telephone)

773-747-4506

Fax #

773-747-4725

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

HFS 3745 (N-4-99)

IL478-2471

#	0054809	Report Period Beginning:	1/1/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

NA

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 12/01/17

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/17 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 231 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL	X	MODIFIED CASH*		CASH*	
--------	---	----------------	--	-------	--

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

Tax Year: 12/31/20 **Fiscal Year:** 12/31/20

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

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **53.37%**

Facility Name & ID Number Landmark Des Plaines Rehab # 0054809 Report Period Beginning: 1/1/20 Ending: 12/31/20
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	411,280	60,182	32,448	503,910		503,910	(69)	503,841			1
2	Food Purchase		331,245		331,245		331,245		331,245			2
3	Housekeeping	356,797	105,682		462,479		462,479		462,479			3
4	Laundry	104,694	27,265		131,959		131,959		131,959			4
5	Heat and Other Utilities			318,912	318,912		318,912	(66)	318,846			5
6	Maintenance	94,878	81,174	113,545	289,597		289,597	(5,195)	284,402			6
7	Other (specify):*											7
8	TOTAL General Services	967,649	605,548	464,905	2,038,102		2,038,102	(5,330)	2,032,772			8
	B. Health Care and Programs											
9	Medical Director			27,200	27,200		27,200		27,200			9
10	Nursing and Medical Records	5,558,764	1,008,330	600,082	7,167,176		7,167,176	(2,979)	7,164,197			10
10a	Therapy			857,129	857,129		857,129		857,129			10a
11	Activities	144,127	24,305		168,432		168,432		168,432			11
12	Social Services	78,737		2,194	80,931		80,931		80,931			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			12,537	12,537		12,537		12,537			15
16	TOTAL Health Care and Programs	5,781,628	1,032,635	1,499,142	8,313,405		8,313,405	(2,979)	8,310,426			16
	C. General Administration											
17	Administrative	148,834		16,640	165,474		165,474		165,474			17
18	Directors Fees											18
19	Professional Services			934,781	934,781		934,781		934,781			19
20	Dues, Fees, Subscriptions & Promotions			5,369	5,369		5,369		5,369			20
21	Clerical & General Office Expenses	235,716	39,130	362,665	637,511		637,511	(15,235)	622,276			21
22	Employee Benefits & Payroll Taxes			1,165,672	1,165,672		1,165,672	(547)	1,165,125			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,172	13,172		13,172		13,172			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			655,960	655,960		655,960		655,960			26
27	Other (specify):*											27
28	TOTAL General Administration	384,550	39,130	3,154,259	3,577,939		3,577,939	(15,782)	3,562,157			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,133,827	1,677,313	5,118,306	13,929,446		13,929,446	(24,091)	13,905,355			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			89,848	89,848		89,848	(3,180)	86,668			30
31	Amortization of Pre-Op. & Org.			9,249	9,249		9,249		9,249			31
32	Interest			7,181	7,181		7,181	(16,467)	(9,286)			32
33	Real Estate Taxes			1,162,038	1,162,038		1,162,038		1,162,038			33
34	Rent-Facility & Grounds			1,601,127	1,601,127		1,601,127		1,601,127			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,869,443	2,869,443		2,869,443	(19,647)	2,849,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,625	2,625		2,625		2,625			38
39	Ancillary Service Centers		855,654		855,654		855,654		855,654			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			352,846	352,846		352,846		352,846			42
43	Other (specify):* Bad Debt			126,662	126,662		126,662	(126,662)				43
44	TOTAL Special Cost Centers		855,654	482,133	1,337,787		1,337,787	(126,662)	1,211,125			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,133,827	2,532,967	8,469,882	18,136,676		18,136,676	(170,400)	17,966,276			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,180)	30		9
10	Interest and Other Investment Income	(16,459)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	1		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	(7,771)	21		18
19	Entertainment				19
20	Contributions	(2,310)	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	(126,662)	43		24
25	Fund Raising, Advertising and Promotional	(5,154)	21		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	(8,795)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (170,400)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (170,400)		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.			\$		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income - Med Records	\$ (619)	10	1
2	Misc Income - Staffing agency	(2,360)	10	2
3	Misc Income Maintenance rebate	(5,195)	6	3
4	Misc Income Utilities	(66)	5	4
5	Misc Income Interest	(8)	32	5
6	Misc Income Work settlement	(547)	22	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	(8,795)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Landmark Des Plaines Rehab

0054809

Report Period Beginning:

1/1/20

Ending:

12/31/20

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	(69)	0	0	0	0	0	0	0	0	0	0	(69)	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	(66)	0	0	0	0	0	0	0	0	0	0	(66)	5
6	Maintenance	(5,195)	0	0	0	0	0	0	0	0	0	0	(5,195)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,330)	0	0	0	0	0	0	0	0	0	0	(5,330)	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	(2,979)	0	0	0	0	0	0	0	0	0	0	(2,979)	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	(2,979)	0	0	0	0	0	0	0	0	0	0	(2,979)	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	(15,235)	0	0	0	0	0	0	0	0	0	0	(15,235)	21
22	Employee Benefits & Payroll Taxes	(547)	0	0	0	0	0	0	0	0	0	0	(547)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	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	(15,782)	0	0	0	0	0	0	0	0	0	0	(15,782)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,091)	0	0	0	0	0	0	0	0	0	0	(24,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Landmark Des Plaines Rehab # 0054809 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(3,180)	0	0	0	0	0	0	0	0	0	0	(3,180)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,467)	0	0	0	0	0	0	0	0	0	0	(16,467)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,647)	0	0	0	0	0	0	0	0	0	0	(19,647)	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):*	(126,662)	0	0	0	0	0	0	0	0	0	0	(126,662)	43
44	TOTAL Special Cost Centers	(126,662)	0	0	0	0	0	0	0	0	0	0	(126,662)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(170,400)	0	0	0	0	0	0	0	0	0	0	(170,400)	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
A & M Healthcare	100	Landmark of Richton Park Rehabilitation and	Richton Park			

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☐ YES☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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			\$			\$ 0	\$ *	39

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											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 Landmark Des Plaines Rehab # 0054809 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Benchmark Funding		X	Working Capital	NA	Various	Various	1,517,788	NA	Various	7,181	6		
7												7		
8												8		
9	TOTAL Facility Related						\$	1,517,788			\$	7,181	9	
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$				\$		14	
15	TOTALS (line 9+line14)						\$	1,517,788			\$	7,181	15	

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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	110,723	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.)			\$	1,057,666	2
3. Under or (over) accrual (line 2 minus line 1).			\$	946,943	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	215,095	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.			\$	1,162,038	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015		8	
		2016	704,501	9	
		2017	717,678	10	
		2018	731,858	11	
		2019	1,057,666	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 Landmark Des Plaines Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054809

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-15-303-013-0000	Nursing Facility	\$ 1,057,666.20	\$ 1,057,666.20
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,057,666.20	\$ 1,057,666.20

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.

A. Square Feet: 52,917

B. General Construction Type: Exterior Brick Frame

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).

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				\$	1
2					2
3	TOTALS			\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11		Wiring for IT Company	2018		10,745	1,026	39	276	(751)	1,102
12		New Phone System	2018		10,888	1,201	39	279	(922)	1,117
13		Replace double door & frame for back door ramp	2018		6,510	834	39	167	(667)	668
14		Replace double door egress doors in basement	2018		5,641	790	39	145	(646)	579
15		Replace wall box single water & drain dialysis room	2018		2,153	110	39	55	(55)	221
16		Replace carpet in administrative area	2018		5,863	301	39	150	(150)	601
17		New doors throughout building	2018		4,107	211	39	105	(105)	421
18		New pump bearing for air handler cooling tower	2018		5,331	273	39	137	(137)	547
19										19
20		New Flooring for 3rd Floor Nursing Station & Employee Lounge	2019		13,989	717	39	359	(359)	717
21		New Double Ejector Pump With Control Panel	2019		14,388	738	39	369	(369)	738
22		New Flooring for Hallway	2019		3,973	204	39	102	(102)	204
23		Paint 1st, 2nd & 3rd Floors	2019		17,562	901	39	450	(450)	901
24		New Entrance Key Pads	2019		2,504	128	39	64	(64)	128
25		2 New Convectors for 2nd Floor Dialysis Room	2019		8,850	454	39	227	(227)	454
26		Remove Existing Carpet & Baseboards, Paint & Patch Walls in Activity O	2019		2,570	132	39	66	(66)	132
27		New Exhaust Fans for GEF 2 and TEF 7	2019		8,913	457	39	229	(229)	457
28		9 Resident Phone Lines on 1st Floor Rooms 101-109	2019		3,508	180	39	90	(90)	180
29		Seal Coat Parking Lot	2019		22,253	1,141	39	571	(571)	1,141
30		New LVT Flooring in Dialysis Room	2019		4,800	246	39	123	(123)	246
31		Replace Burner Control for Boiler B	2019		3,741	192	39	96	(96)	192
32		New Valve/Damper Actuator for Boiler A	2019		3,570	183	39	92	(92)	183
33		Install New OEM Heat Exchange on Boiler C	2019		4,859	249	39	125	(125)	249
34		Install New Wanderer System on Lower Level Double Doors	2019		3,675	188	39	94	(94)	188
35		Remove & Install Metal Railing for Commercial Building	2019		2,831	145	39	73	(73)	145
36		Remove All Carpet, Repair Damaged Concrete, Install New Flooring in M	2019		6,335	325	39	162	(162)	325

*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 Landmark Des Plaines Rehab

0054809

Report Period Beginning:

1/1/20

Ending:

12/31/20

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	New Luxury Vinyl Tile for Upper & Lower Lobbies	2019	3,459	177	39	89	(88)	177	38
39									39
40	Remove Wallpaper, Patch & Prime Walls, Paint Walls, Doors & M	2020	2,400	62	39	62		62	40
41	Replace Leaking Mixing Valve for Kitchen Air Handler	2020	3,922	101	39	101		101	41
42	Walk Off Tile for Vestibule	2020	3,862	99	39	99		99	42
43	Install Stair Tread & Stair Nose Thresholds, Reomve Old Carpet i	2020	2,375	61	39	56	(5)	61	43
44	Remove Broken Tile, Install New Tile, Repair Concrete Underlay	2020	2,975	76	39	64	(13)	76	44
45	Remove Wallpaper, Patch & Prime Walls, Paint Walls, Doors & M	2020	2,650	68	39	57	(11)	68	45
46	2 New Air Coils for Building Main Air Handler	2020	17,961	461	39	345	(115)	461	46
47	New Pump Motor A for Chiller	2020	1,985	51	39	30	(21)	51	47
48	Rip Gas Lines and Create Drain for New Kitchen Steamer	2020	3,633	93	39	54	(39)	93	48
49	Grandstream 48 Port Placement ATA for Phone System	2020	2,164	55	39	28	(28)	55	49
50	New Exit/Stairwell Door	2020	5,130	132	39	55	(77)	132	50
51	New Air Conditioner for Lobby	2020	5,960	153	39	51	(102)	153	51
52	2 Grandstream 48 Port Analog Telephone Adaptors	2020	4,006	103	39	34	(68)	103	52
53	Replace Main Air Handler Dampers	2020	5,100	131	39	22	(109)	131	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)		\$ 247,142	\$ 13,149		\$ 5,749	\$ (7,400)	\$ 13,657	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	\$272,952	\$50,608	\$54,590	\$3,982	5	\$119,748	71
72	Current Year Purchases	131,639	26,091	26,328	237	5	26,091	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$404,591	\$76,699	\$80,918	\$4,219		\$145,839	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)	\$651,733	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$89,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$86,667	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,180)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$159,496	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Landmark of Des Plaines Rehab Ctr
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ 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:	1974	231		\$1,588,600			3
4	Additions							4
5								5
6								6
7	TOTAL		231		\$1,588,600			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:\$N/ADescription:
(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

10. Effective dates of current rental agreement:
Beginning12/01/2017
Ending11/30/2022

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

	Fiscal Year Ending	Annual Rent
12.	12/2021	\$1,625,729
13.	12/2022	\$1,658,244
14.	12/2023	\$1,691,409

* 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.

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)	\$			

- (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.

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	

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

12345678										
	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	10a-3	hrs	\$	7,006	\$ 365,442	\$	7,006	\$ 365,442	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,299	92,835		1,299	92,835	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,629	398,852		6,629	398,852	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				546,909		546,909	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					24,720		24,720	12
13	Other (specify): Lab	39-2					284,024		284,024	13
14	TOTAL			\$	14,934	\$ 857,129	\$ 855,654	14,934	\$ 1,712,783	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (466,867)	\$ (466,867)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,483,450	5,483,450	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	275,952	275,952	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,292,535	\$ 5,292,535	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	247,142	247,142	15
16	Equipment, at Historical Cost	404,591	404,591	16
17	Accumulated Depreciation (book methods)	(166,308)	(166,308)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,745	27,745	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,434)	(13,434)	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)	\$ 499,736	\$ 499,736	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,792,271	\$ 5,792,271	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,291,192	\$ 1,291,192	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,004,104	6,004,104	29
30	Accrued Salaries Payable	198,405	198,405	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,571	27,571	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,521,272	\$ 7,521,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,521,272	\$ 7,521,272	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,729,001)	\$ (1,729,001)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,792,271	\$ 5,792,271	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,238,325	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,238,325	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(362,697)	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	(3,604,631)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,967,326)	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)	\$ (1,729,001)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Landmark Des Plaines Rehab

0054809

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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	\$ 18,659,734	1
2	Discounts and Allowances for all Levels	(3,016,098)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,643,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	290,645	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 290,645	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,698,970	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	478	19
20	Radiology and X-Ray	114,492	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,813,940	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,459	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,459	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	440	28
28a	Misc Income	8,859	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,299	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,773,979	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,038,102	31
32	Health Care	8,313,405	32
33	General Administration	3,577,939	33
	B. Capital Expense		
34	Ownership	2,869,443	34
	C. Ancillary Expense		
35	Special Cost Centers	1,337,787	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,136,676	40
41	Income before Income Taxes (line 30 minus line 40)**	(362,697)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (362,697)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,153,861	44
45	Private Pay - Net Inpatient Revenue	439,325	45
46	Medicare - Net Inpatient Revenue	3,956,720	46
47	Other-(specify)	1,093,729	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,643,636	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.

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	928	1,045	\$ 54,588	\$ 52.24	1
2	Assistant Director of Nursing	6,717	7,140	279,546	39.15	2
3	Registered Nurses	27,854	33,426	1,225,835	36.67	3
4	Licensed Practical Nurses	28,398	33,256	1,130,609	34.00	4
5	CNAs & Orderlies	68,317	89,467	1,736,286	19.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	26,705	29,841	970,406	32.52	8
9	Activity Director					9
10	Activity Assistants	7,892	8,591	144,127	16.78	10
11	Social Service Workers	3,710	3,927	78,737	20.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,994	25,205	411,280	16.32	15
16	Dishwashers					16
17	Maintenance Workers	3,767	4,277	94,878	22.18	17
18	Housekeepers	20,516	23,253	318,639	13.70	18
19	Laundry	7,203	7,932	104,694	13.20	19
20	Administrator	2,032	2,080	148,834	71.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,192	13,846	287,368	20.75	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	4,882	3,008	148,001	49.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	244,107	286,294	\$ 7,133,828 *	\$ 24.92	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	676	\$ 32,448	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	251	12,537	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	34	2,194	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	961	\$ 47,179		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	3,420	600,082	10-2	52
53	TOTAL (lines 50 - 52)	3,420	\$ 600,082		53

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

** See instructions.

STATE OF ILLINOIS

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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	
Kouzos, Demetrios		Administrator	0	\$ 148,834	Workers' Compensation Insurance		\$ 166,598	IDPH License Fee		\$	
					Unemployment Compensation Insurance		62,574	Advertising: Employee Recruitment			
					FICA Taxes		532,781	Health Care Worker Background Check			
					Employee Health Insurance		382,138	(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			The Joint commision		2,700	
					Uniforms		3,526	Cook County Collector		189	
					Employee backround check		2,320	Park Colony		1,225	
					Other employee benefits		15,188	Cook County Dept of envirement		394	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 148,834				Other fees and dues		861	
B. Administrative - Other								Less: Public Relations Expense		()	
Description			Amount					Non-allowable advertising		()	
			\$					Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,165,125	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,369	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services			Amount		Description		Line #	Amount	Description		Amount
Vendor/Payee		Type							Out-of-State Travel		\$
BENCHMARK HEALTH CARE CO		Management Fee	\$ 644,333						Travel Reimbursement		224
Admiral Environmental Services Inc		Professional fees	513								
Apex Global Solutions FL, LLC		Professional fees	40,293						In-State Travel		
BENCHMARK HEALTH CARE CO		Management Fee	12,386						Travel Reimbursement		10,652
Credit Suisse		Legal	2,310								
Empire Risk Management Services, I		Risk Management	11,421						Seminar Expense		
Genex Services LLC		Professional fees	87						Education and Seminars		2,295
Global Fiscal Midwest, LLC		Professional fees	58,494								
INFINITY HEALTH CARE MGMT		Management Fee	167						Entertainment Expense		()
Abbey Road		Legal Fee	93,015						(agree to Sch. V, line 24, col. 8)		
									TOTAL		\$ 13,172
See attached schedule			71,763								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 934,781	TOTAL		\$				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Landmark Des Plaines Rehab	STATE OF ILLINOIS # 0054809	Report Period Beginning: 1/1/20	Ending: 12/31/20
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. N/A

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 137,115 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. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 352,846
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A

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

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