FOR BHF USE

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0054809

Facility Name: Landmark of Des Plaines Rehab Ctr

Address: 9300 W Ballard Rd (Number) Des Plaines (City) 60016 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar Telephone Number: (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,112	2,483	7,518	42,113	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,112	2,483	7,518	42,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.95%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/17

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/17 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 231 and days of care provided 5,516

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	349,254	21,199	30,498	400,951		400,951	(834)	400,117			1
2	Food Purchase		243,467		243,467		243,467	1,179	244,646			2
3	Housekeeping	197,276	41,265		238,541		238,541	12	238,553			3
4	Laundry	93,666	49,392		143,058		143,058		143,058			4
5	Heat and Other Utilities			320,562	320,562		320,562	2,000	322,562			5
6	Maintenance	114,871	38,193	137,031	290,095		290,095	(1,060)	289,035			6
7	Other (specify):*											7
8	TOTAL General Services	755,067	393,516	488,091	1,636,674		1,636,674	1,297	1,637,971			8
	B. Health Care and Programs											
9	Medical Director			42,725	42,725		42,725		42,725			9
10	Nursing and Medical Records	4,970,886	864,077		5,834,963		5,834,963	34,619	5,869,582			10
10a	Therapy	1,064,322		972,727	2,037,049		2,037,049		2,037,049			10a
11	Activities	137,882	12,498		150,380		150,380	(981)	149,399			11
12	Social Services	55,601		9,855	65,456		65,456		65,456			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			12,006	12,006		12,006	(257)	11,749			15
16	TOTAL Health Care and Programs	6,228,691	876,575	1,037,313	8,142,579		8,142,579	33,381	8,175,960			16
	C. General Administration											
17	Administrative	131,963			131,963		131,963	(15,756)	116,207			17
18	Directors Fees											18
19	Professional Services			853,684	853,684		853,684	(609,120)	244,564			19
20	Dues, Fees, Subscriptions & Promotions			6,998	6,998		6,998	(2,775)	4,223			20
21	Clerical & General Office Expenses	141,705	103,467	97,510	342,682		342,682	243,218	585,900			21
22	Employee Benefits & Payroll Taxes			1,153,729	1,153,729		1,153,729	40,724	1,194,453			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,912	6,912		6,912	10,105	17,017			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			443,589	443,589		443,589	1,039	444,628			26
27	Other (specify):*											27
28	TOTAL General Administration	273,668	103,467	2,562,422	2,939,557		2,939,557	(332,565)	2,606,992			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,257,426	1,373,558	4,087,826	12,718,810		12,718,810	(297,887)	12,420,923			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr #0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,733	17,733		17,733	738,933	756,666			30
31	Amortization of Pre-Op. & Org.							349,509	349,509			31
32	Interest			6,691	6,691		6,691	728,023	734,714			32
33	Real Estate Taxes							731,678	731,678			33
34	Rent-Facility & Grounds			2,159,201	2,159,201		2,159,201	(2,155,346)	3,855			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,183,625	2,183,625		2,183,625	392,797	2,576,422			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			456	456		456		456			38
39	Ancillary Service Centers		679,081		679,081		679,081	(8,758)	670,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,528	295,528		295,528		295,528			42
43	Other (specify):* **Bad Debt Expense**			630	630		630	(630)				43
44	**TOTAL Special Cost Centers**		679,081	296,614	975,695		975,695	(9,388)	966,307			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,257,426	2,052,639	6,568,065	15,878,130		15,878,130	85,522	15,963,652			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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	189,208	30		9
10	Interest and Other Investment Income	(4,076)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	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	(1,594)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(630)	43		24
25	Fund Raising, Advertising and Promotional	(9,841)	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	(11,587)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 161,405		$	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)	(75,883)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (75,883)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 85,522		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Landmark of Des Plaines Rehab Ctr

ID# 0054809

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (288)	10	1
2	RP Profit	(257)	15	2
3	RP Profit	(8,758)	39	3
4	Misc Income	(1,591)	21	4
5	Vending Income	(693)	1	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**	(11,587)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(768)	0	(66)	0	0	0	0	0	0	0	0	(834)	1
2	Food Purchase	0	1,179	0	0	0	0	0	0	0	0	0	1,179	2
3	Housekeeping	0	12	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,948	52	0	0	0	0	0	0	0	0	2,000	5
6	Maintenance	0	1,068	(2,128)	0	0	0	0	0	0	0	0	(1,060)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(768)	4,207	(2,142)	0	0	0	0	0	0	0	0	1,297	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	(288)	36,180	(1,273)	0	0	0	0	0	0	0	0	34,619	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	(981)	0	0	0	0	0	0	0	0	(981)	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):*	(257)	0	0	0	0	0	0	0	0	0	0	(257)	15
16	**TOTAL Health Care and Programs**	(545)	36,180	(2,254)	0	0	0	0	0	0	0	0	33,381	16
	C. General Administration													
17	Administrative	0	(15,756)	0	0	0	0	0	0	0	0	0	(15,756)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,498	(610,618)	0	0	0	0	0	0	0	0	(609,120)	19
20	Fees, Subscriptions & Promotions	0	114	(2,889)	0	0	0	0	0	0	0	0	(2,775)	20
21	Clerical & General Office Expenses	(13,026)	200,172	56,072	0	0	0	0	0	0	0	0	243,218	21
22	Employee Benefits & Payroll Taxes	0	30,728	9,996	0	0	0	0	0	0	0	0	40,724	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,591	6,514	0	0	0	0	0	0	0	0	10,105	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	1,039	0	0	0	0	0	0	0	0	0	1,039	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,026)	221,386	(540,925)	0	0	0	0	0	0	0	0	(332,565)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,339)	261,773	(545,321)	0	0	0	0	0	0	0	0	(297,887)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	189,208	0	549,725	0	0	0	0	0	0	0	0	738,933	30
31	Amortization of Pre-Op. & Org.	0	0	349,509	0	0	0	0	0	0	0	0	349,509	31
32	Interest	(4,076)	0	732,099	0	0	0	0	0	0	0	0	728,023	32
33	Real Estate Taxes	0	0	731,678	0	0	0	0	0	0	0	0	731,678	33
34	Rent-Facility & Grounds	0	0	(2,155,346)	0	0	0	0	0	0	0	0	(2,155,346)	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**	185,132	0	207,665	0	0	0	0	0	0	0	0	392,797	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	(8,758)	0	0	0	0	0	0	0	0	0	0	(8,758)	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):*	(630)	0	0	0	0	0	0	0	0	0	0	(630)	43
44	**TOTAL Special Cost Centers**	(9,388)	0	0	0	0	0	0	0	0	0	0	(9,388)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	161,405	261,773	(337,656)	0	0	0	0	0	0	0	0	85,522	45

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	Ambassabor Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Mgmt Co
		Belhaven Nursing & Rehab Center	Chicago	Ballard Real Estate LLC		Property Co
		City View Multicare Center	Cicero	Benchmark Management		Mgmt Co
		Continental Nursing & Rehab Center	Chicago			
		Forest View Nursing & Rehab Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Nursing & Rehab Center	Bridgeview			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Infinity Healthcare Management		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management		1,179	1,179	2
3	V	3	Housekeeping		Infinity Healthcare Management		12	12	3
4	V	5	Utilities		Infinity Healthcare Management		1,948	1,948	4
5	V	6	Maintenance		Infinity Healthcare Management		1,068	1,068	5
6	V	10	Nursing		Infinity Healthcare Management		36,180	36,180	6
7	V	19	Professional Fees	153	Infinity Healthcare Management		1,651	1,498	7
8	V	20	Dues & Fees		Infinity Healthcare Management		114	114	8
9	V	21	Office Expense	1,686	Infinity Healthcare Management		201,858	200,172	9
10	V	22	Employee Benefits		Infinity Healthcare Management		30,728	30,728	10
11	V	24	Travel & Seminar	64	Infinity Healthcare Management		3,655	3,591	11
12	V	26	Insurance		Infinity Healthcare Management		1,039	1,039	12
13	V	17	Administrative	15,756	Infinity Healthcare Management			(15,756)	13
14	Total			$ 17,659			$ 279,432	$ * 261,773	14

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Infinity Healthcare Management		$ 3,368	$ 3,368	15
16	V	34	Rent		Infinity Healthcare Management		3,855	3,855	16
17	V								17
18	V	21	Office Expense		Ballard Real Estate, LLC		565	565	18
19	V	30	Depreciation		Ballard Real Estate, LLC		549,725	549,725	19
20	V	31	Amortization		Ballard Real Estate, LLC		349,509	349,509	20
21	V	32	Interest		Ballard Real Estate, LLC		728,731	728,731	21
22	V	33	Real Estate Tax		Ballard Real Estate, LLC		731,678	731,678	22
23	V	34	Rent	2,159,201	Ballard Real Estate, LLC			(2,159,201)	23
24	V								24
25	V	5	Utilities		Benchmark Management		52	52	25
26	V	10	Nursing	2,381	Benchmark Management		1,108	(1,273)	26
27	V	19	Professional Fees	640,902	Benchmark Management		30,284	(610,618)	27
28	V	20	Dues & Fees	3,310	Benchmark Management		421	(2,889)	28
29	V	21	Office Expense	5,780	Benchmark Management		61,287	55,507	29
30	V	22	Employee Benefits		Benchmark Management		9,996	9,996	30
31	V	24	Travel & Seminar		Benchmark Management		6,514	6,514	31
32	V	1	Dietary	66				(66)	32
33	V	6	Maintenance	2,128				(2,128)	33
34	V	11	Activities	981				(981)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,814,749			$ 2,477,093	$ * (337,656)	39

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomingdale				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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X	Mortgage		12/8/14	$ 29,200,000	$ 17,857,459	12/8/24	4.0000	$ 738,791	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 29,200,000	$ 17,857,459			$ 738,791	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 29,200,000	$ 17,857,459			$ 738,791	15

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

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

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	717,678	2
3. Under or (over) accrual (line 2 minus line 1).	$	717,678	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	14,000	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.	$	731,678	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015		10
2016		11
2017	717,678	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Landmark of Des Plaines Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054809

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	Nursing Facility	$ 717,677.69	$ 717,677.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 717,677.69	$ 717,677.69

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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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 [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	83,740	2014	$ 1,100,000	1
2					2
3	TOTALS	83,740		$ 1,100,000	3

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2014	1974	$ 10,680,000	$ 356,000	30	$ 356,000	$	$ 1,424,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Prior Year Building Improvements			2017	130,745	8,000	39	3,352	(4,648)	32,000	10
11											11
12	New Phone System			2018	10,888		39	279	279		12
13	Replace double door & frame for back door ramp			2018	6,510		39	167	167		13
14	Replace double egress doors in basement			2018	5,641		39	145	145		14
15	Replace wall box single water & drain dialysis room			2018	2,153		39	55	55		15
16	Replace carpet in administrative area			2018	5,863		39	150	150		16
17	New doors throughout building			2018	4,107		39	105	105		17
18	New pump bearing for air handler cooling tower			2018	5,331		39	137	137		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

*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 of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 10,851,238	$ 364,000		$ 360,390	$ (3,610)	$ 1,456,000	70

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,926,502	$ 195,618	$ 385,300	$ 189,682	5	$ 706,417	71
72	Current Year Purchases	54,880	7,840	10,976	3,136		7,840	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,981,382	$ 203,458	$ 396,276	$ 192,818		$ 714,257	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)	$ 13,932,620	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 567,458	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 756,666	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 189,208	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,170,257	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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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.

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	7,709	$ 425,972	$	7,709	$ 425,972	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,167	60,681		1,167	60,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		7,787	486,074		7,787	486,074	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				430,464		430,464	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & X-Ray	39-2					248,617		248,617	12
13	Other (specify):									13
14	TOTAL			$	16,663	$ 972,727	$ 679,081	16,663	$ 1,651,808	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 Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (142,204)	$ 1,048,794	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,850,469	4,834,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	295,834	295,834	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)**	$ 6,004,099	$ 6,179,581	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		10,680,000	14
15	Leasehold Improvements, at Historical Cost	51,238	171,238	15
16	Equipment, at Historical Cost	124,128	1,981,382	16
17	Accumulated Depreciation (book methods)	(18,532)	(2,170,257)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		3,312,546	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,400,935)	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)**	$ 156,834	$ 13,673,974	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,160,933	$ 19,853,555	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,743,953	$ 3,568,737	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,546	186,546	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,235	22,235	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)**	$ 2,952,734	$ 3,777,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		17,857,459	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)**	$	$ 17,857,459	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,952,734	$ 21,634,977	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,208,199	$ (1,781,422)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,160,933	$ 19,853,555	48

***(See instructions.)**

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,616,995	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,616,995	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,408,796)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,408,796)	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)**	$ 3,208,199	24 *

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

Facility Name & ID Number Landmark of Des Plaines Rehab Ctr # 0054809 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,178,677	1
2	Discounts and Allowances for all Levels	(918,606)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,260,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,058,544	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,058,544	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	133,009	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,074	19
20	Radiology and X-Ray	4,750	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 145,833	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,602	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,602	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,284	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,284	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,469,334	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,636,674	31
32	Health Care	8,142,579	32
33	General Administration	2,939,557	33
	B. Capital Expense		
34	Ownership	2,183,625	34
	C. Ancillary Expense		
35	Special Cost Centers	679,081	35
36	Provider Participation Fee	295,528	36
	D. Other Expenses (specify):		
37	Medicall Necessary Transportation	456	37
38	Bad Debt Expense	630	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,878,130	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,408,796)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,408,796)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,376,755	44
45	Private Pay - Net Inpatient Revenue	1,160,067	45
46	Medicare - Net Inpatient Revenue	3,798,929	46
47	Other-(specify)	924,320	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,260,071	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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,688	2,861	$ 147,512	$ 51.56	1
2	Assistant Director of Nursing	16,902	18,099	513,872	28.39	2
3	Registered Nurses	45,534	49,031	1,675,743	34.18	3
4	Licensed Practical Nurses	25,337	26,812	757,606	28.26	4
5	CNAs & Orderlies	85,352	92,048	1,500,597	16.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	34,412	37,985	1,064,322	28.02	8
9	Activity Director	7,137	8,053	137,882	17.12	9
10	Activity Assistants					10
11	Social Service Workers	2,289	2,409	55,601	23.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,738	25,524	349,254	13.68	15
16	Dishwashers					16
17	Maintenance Workers	5,132	6,313	114,871	18.20	17
18	Housekeepers	15,607	17,303	197,276	11.40	18
19	Laundry	7,896	8,503	93,666	11.02	19
20	Administrator	1,874	2,110	131,963	62.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,272	7,474	141,705	18.96	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	5,881	6,422	88,892	13.84	31
32	Other Health C: MDS	5,251	5,596	182,979	32.70	32
33	Other(specify) Admissions	2,108	2,343	103,685	44.25	33
34	TOTAL (lines 1 - 33)	295,410	318,886	$ 7,257,426 *	$ 22.76	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	649	$ 30,498	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	240	12,006	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	159	9,855	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,048	$ 52,359		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marla Costello	Administrator		$ 39,424
Demetrios Kouzios	Administrator		92,539
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,963

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paychex	Accounting	$ 15,103
Infinity Funding/Sedgwick	Legal	18,882
Global Fiscal Midwest	Professional	103,303
Empire Risk Mgmt	Professional	7,050
USA Risk Mgmt	Professional	6,010
Various/Other	Professional	6,197
Infinity Healthcare Mgmt	Management	50,238
Empire Risk Mgmt	Management	6,000
Benchmark Consultants	Management	640,901
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 853,684

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,075
Unemployment Compensation Insurance	101,026
FICA Taxes	555,817
Employee Health Insurance	315,848
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	11,349
Employee Background Check	1,169
Employee Expense	5,169
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,194,453

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Benchmark	3,310
Cook County	438
State Fire Marshal	560
Various	700
Home Office	(2,775)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,223

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	10,105
Mileage	6,580
Seminar Expense	
Education	332
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,017

* Attach copy of IMRF notifications

**See instructions.

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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? **No**
If YES, give association name and amount. **N/A**

(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? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **112,052** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **295,528**
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 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