Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 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	174	Skilled (SNF)	174	63,510	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	174	TOTALS	174	63,510	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	1,367	8,780	2,480	12,627	8
9	SNF/PED					9
10	ICF		3,813		3,813	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,367	12,593	2,480	16,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 25.89%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

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 01/01/1977

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	187,143	15,618	7,372	210,133		210,133		210,133			1
2	Food Purchase		216,577		216,577		216,577		216,577			2
3	Housekeeping	55,700	9,705		65,405		65,405		65,405			3
4	Laundry	23,698	2,793	16,310	42,801		42,801		42,801			4
5	Heat and Other Utilities			181,226	181,226		181,226	(1,104)	180,122			5
6	Maintenance	112,233	14,853	65,676	192,762		192,762		192,762			6
7	Other (specify):*											7
8	TOTAL General Services	378,774	259,546	270,584	908,904		908,904	(1,104)	907,800			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	1,035,062	89,549	161,022	1,285,633		1,285,633		1,285,633			10
10a	Therapy			3,014	3,014		3,014		3,014			10a
11	Activities	75,182	10,530	459	86,171		86,171		86,171			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,110,244	100,079	170,595	1,380,918		1,380,918		1,380,918			16
	C. General Administration											
17	Administrative	175,180			175,180		175,180		175,180			17
18	Directors Fees											18
19	Professional Services			64,018	64,018		64,018	(5,557)	58,461			19
20	Dues, Fees, Subscriptions & Promotions			6,911	6,911		6,911		6,911			20
21	Clerical & General Office Expenses	129,684	10,209	56,465	196,358		196,358	(23,336)	173,022			21
22	Employee Benefits & Payroll Taxes			342,037	342,037		342,037		342,037			22
23	Inservice Training & Education			180	180		180		180			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			812	812		812	53	865			25
26	Insurance-Prop.Liab.Malpractice			114,126	114,126		114,126		114,126			26
27	Other (specify):*											27
28	TOTAL General Administration	304,864	10,209	584,549	899,622		899,622	(28,840)	870,782			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,793,882	369,834	1,025,728	3,189,444		3,189,444	(29,944)	3,159,500			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Libertyville Manor #0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			170,234	170,234		170,234	(70,869)	99,365			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,514	26,514		26,514		26,514			32
33	Real Estate Taxes			187,862	187,862		187,862		187,862			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			384,610	384,610		384,610	(70,869)	313,741			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	262,037	81,677	15,508	359,222		359,222		359,222			39
40	Barber and Beauty Shops			6,835	6,835		6,835		6,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,264	173,264		173,264		173,264			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	262,037	81,677	195,607	539,321		539,321		539,321			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,055,919	451,511	1,605,945	4,113,375		4,113,375	(100,813)	4,012,562			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	4,403	28		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(70,869)	30		9
10	Interest and Other Investment Income	53	25		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	565	5		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				18
19	Entertainment	1,155	21		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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See schedule Attached				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,693)	39	$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (64,693)		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

SEE ACCOUNTANTS' PREPARATION REPORT

Libertyville Manor

ID# 0017780

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (7,856)	21	1
2	NON ALLOWABLE LEGAL FEES	(5,557)	19	2
3	PUBLIC RELATIONS	(1,669)	5	3
4	VENDING EXPENSE	(1,585)	21	4
5	MISCELLANEOUS REVENUE	(12,595)	21	5
6	NON CARE SUPPLIES	(2,455)	21	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**	(31,717)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Libertyville Manor # 0017780 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,104)	0	0	0	0	0	0	0	0	0	0	(1,104)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,104)	0	0	0	0	0	0	0	0	0	0	(1,104)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,557)	0	0	0	0	0	0	0	0	0	0	(5,557)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(23,336)	0	0	0	0	0	0	0	0	0	0	(23,336)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	53	0	0	0	0	0	0	0	0	0	0	53	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**	(28,840)	0	0	0	0	0	0	0	0	0	0	(28,840)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,944)	0	0	0	0	0	0	0	0	0	0	(29,944)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Libertyville Manor **#** 0017780 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(70,869)	0	0	0	0	0	0	0	0	0	0	(70,869)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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**	(70,869)	0	0	0	0	0	0	0	0	0	0	(70,869)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(100,813)	0	0	0	0	0	0	0	0	0	0	(100,813)	45

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPPLEMENTAL				SEE PAGE 6 SUPPLEMENTAL		

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

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

1 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
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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	MILAN STOKOVICH	50%			SB HOLDINGS, LTD	LIBERTYVILLE	BUILDING CO	1
2	JOHN STOKOVICH	505			YOUNG AT HEART	LIBERTYVILLE	DAY CARE	2
3					AMERICAN HOME HEALTHCARE		HOME HEALTH	3
4						LIBERTYVILLE	CARE	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOHN STOKOVICH	OWNER	ADMINISTRATO	50.00	NONE	40	100.00	SALARY	$ 87,554	17-01	1
2	MILAN STOKOVICH	OWNER	ASSIT ADMIN	50.00	NONE	40	100.00	SALARY	87,628	17-01	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 175,182		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 Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	LIBERTYVILLE BANK AND TRUS	X		REMODELING LOAN			$ 650,000	$ 650,000			$ 26,514	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 650,000	$ 650,000			$ 26,514	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 650,000	$ 650,000			$ 26,514	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 205,000	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.)		$ 182,025	2
3. Under or (over) accrual (line 2 minus line 1).		$ (22,975)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 210,837	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.		$ 187,862	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	213,991	8
	2013	233,839	9
	2014	196,031	10
	2015	195,561	11
	2016	181,640	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Libertyville Manor COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0017780

CONTACT PERSON REGARDING THIS REPORT RICHARD HOOPIS

TELEPHONE (847) 441-2300 FAX #: (847) 441-4435

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-08-100-035	LONG TERM CARE FACILITY	$ 182,025.00	$ 182,025.00
2.	11-08-100-036	LONG TERM CARE FACILITY	$ 14,753.00	$ 14,753.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 196,778.00	$ 196,778.00

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 97,000 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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 [ ] (b) Rent equipment from a Related Organization. [X] (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).

YAUNG AT HEART DAT CARE (6500 SQ FT)

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	FACILITY			$ 635,798	1
2					2
3	TOTALS			$ 635,798	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	129		1977	1977	$ 1,696,312	$	39	$	$	$ 1,696,312	4
5	45			1989	1,778,086		39	43,495	43,495	1,370,159	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1981	1937		20			1,937	9
10	VARIOUS			1984	408		20			408	10
11	VARIOUS			1987	63958		20			63,958	11
12	VARIOUS			1988	15655		20			15,655	12
13	VARIOUS			1989	387566		20			387,566	13
14	VARIOUS			1990	23736		20			23,736	14
15	VARIOUS			1991	120450		20	3,824	3,824	100,574	15
16	VARIOUS			1992	115412		20	3,244	3,244	96,524	16
17	VARIOUS			1993	44742		20	754	754	33,660	17
18	VARIOUS			1994	15914		20	275	275	11,593	18
19	VARIOUS			1996	12196		20	128	128	10,009	19
20	VARIOUS			1997	13506		20	208	208	9,687	20
21	VARIOUS			2003	63766		20	1,635	1,635	22,958	21
22	VARIOUS			2004	27455		20	538	538	26,646	22
23	VARIOUS			2005	23184		20			23,184	23
24	VARIOUS			2012	22782		20	835	835	4,837	24
25	VARIOUS			2013	9,653		20	483	483	2,415	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.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	RELATED BUILDING COMPANY :								62
63	LEASEHOLD IMPROVMENTS	1989	23,269		20			23,269	63
64	WELL DRILLING	1992	4,634		20			4,634	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,464,621	$		$ 55,419	$ 55,419	$ 3,929,721	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,464,621	$		$ 55,419	$ 55,419	$ 3,929,721	1
2	DEMOLITION AND REBUILD INTERIOR PLUMBING								2
3	DRYWALL, PLUMBING,HVAC, ELECTRICAL	2015	588,045		20	29,402	29,402	88,206	3
4	GAS HEATING PTAC WITH CO2 DETECTOR(11117)	2015	10,310		20	515	515	1,030	4
5	EXHAUST FANS	2015	6,069		20	303	303	606	5
6	ROOF REPAIRS NEW CAPS AND SEAL ELECTRICAL	2016	8,068		20	403	403	806	6
7	SPA TUB	2016	12,100		20	605	605	1,210	7
8	A/C UNITS	2016	5,773		20	289	289	578	8
9	WING 300-400 REMODELING INCLUDE ALL OF LINE1 AND	2016	236,919		20	11,486	11,486	23,692	9
10									10
11	PLUMBING REPAIRS	2017	3,117		20	156	156	156	11
12	REMODELING EXPENSES	2017	15,745		20	787	787	787	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,350,767	$		$ 99,365	$ 99,365	$ 4,046,792	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 838,841	$	$	$	10	$ 248,893	71
72	Current Year Purchases	3,000				10	30	72
73	Fully Depreciated Assets	1,779,993				10	1,779,993	73
74								74
75	TOTALS	$ 2,621,834	$	$	$		$ 2,028,916	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		SEE SCHEDULE ATTACHED		$ 120,386	$	$	$	5	$ 120,386	76
77										77
78										78
79										79
80	TOTALS			$ 120,386	$	$	$		$ 120,386	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)	$ 8,728,785	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,365	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 99,365	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,196,094	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	AUTO -2014	$ 9,929	$	$	86
87	LEASEHOLD IMPROVEMENTS 2014	139,126			87
88	EQUIPMENT 2014	120,412			88
89	BUILDING 2014	1,844,736			89
90	2015 NON CARE PORTION(7.62%)	112,944			90
91	TOTALS	$ 2,227,147	$	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ NONE 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-01	hrs	$ 68,042		$ 150	$		$ 68,192	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	193,996		10,167			204,163	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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): CHICAGO MEDICAL	39-02				79,647			79,647	12
13	Other (specify): OXYGEN SUPPLIES	39-02				2,030			2,030	13
14	TOTAL			$ 262,038		$ 91,994	$		$ 354,032	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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Libertyville Manor **#** 0017780 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 501,195	$ 533,172	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	512,601	512,601	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	6,972	6,972	5
6	Prepaid Insurance	3,570	3,570	6
7	Other Prepaid Expenses	33,163	33,163	7
8	Accounts Receivable (owners or related parties)	356,100	356,100	8
9	Other(specify): See Attached Schedule	62,142	62,142	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,475,743	$ 1,507,720	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		635,798	13
14	Buildings, at Historical Cost		5,319,135	14
15	Leasehold Improvements, at Historical Cost	2,333,955	5,609,252	15
16	Equipment, at Historical Cost	3,063,292	3,383,292	16
17	Accumulated Depreciation (book methods)	(3,977,282)	(10,335,109)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,419,965	$ 4,612,368	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,895,708	$ 6,120,088	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 83,606	$ 134,071	26
27	Officer's Accounts Payable	770,932	770,932	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,686	103,686	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,477	9,477	31
32	Accrued Real Estate Taxes(Sch.IX-B)	210,837	205,000	32
33	Accrued Interest Payable		31,455	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)**	$ 1,178,538	$ 1,254,621	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	See Attached Schedule	4,962,639	4,250,883	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,962,639	$ 4,250,883	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,141,177	$ 5,505,504	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,245,469)	$ 614,584	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,895,708	$ 6,120,088	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

STATE OF ILLINOIS

Facility Name & ID Numb Libertyville Manor # 0017780 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

Supplemental Schedule of other Assets and Liabilities as of 12/31/2017

	Other Current Assets:	Amount	Amount
09A	A/R Other	$ 31,018	$ 31,018
09B	Due Fr Gurnee Land	$ 26,346	$ 26,346
09C	Due Fr Lake Devel.	$ 4,778	$ 4,778
09D			
09E			
09F			
09F			
09G			
		$ 62,142	$ 62,142

	Other Current Liabilities	Amount	Amount
36A	Due to SB Holdings	$ 127,107	$ (584,649)
36B	Due to Peterson Rd Inv	$ 2,646,036	$2,646,036
36C	Due to Stokovich Family LTD	$ 1,107,077	$1,107,077
36D	Due to Libertyville Farms	$ 371,322	$ 371,322
36E	due to Est of N. Stokovich	$ 711,097	$ 711,097
36F			
36G			
		$ 4,962,639	$4,250,883

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,727,877)	1
2	Restatements (describe):		2
3	**Closing Entries for 2016 were posted in 2017 after '16 Closed**	(472,648)	3
4	**Error in prior year in Capital Stock was corrected**	(25,000)	4
5	**Prior year afdjustment for expenditures not recorded**	(679)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,226,204)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(40,873)	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) **Unrealized Gain/(Loss)**	21,608	15
16	Other (describe) **Purchase of Deceased Partner's Stock**	(1,000,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,019,265)	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)**	$ (3,245,469)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 3,990,343	1
2	Discounts and Allowances for all Levels	(161,547)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,828,796	3
	B. Ancillary Revenue		
4	Day Care	38,743	4
5	Other Care for Outpatients		5
6	Therapy	18,891	6
7	Oxygen	1,676	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 59,310	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	7,374	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	4,403	15
16	Rental of Facility Space	79,200	16
17	Sale of Drugs	1,026	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	44,748	21
22	Laundry	16,255	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 153,006	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		31,337	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,072,502	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	908,904	31
32	Health Care	1,380,918	32
33	General Administration	899,622	33
	B. Capital Expense		
34	Ownership	384,610	34
	C. Ancillary Expense		
35	Special Cost Centers	366,057	35
36	Provider Participation Fee	173,264	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,113,375	40
41	**Income before Income Taxes (line 30 minus line 40)****	(40,873)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (40,873)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 100,438	44
45	Private Pay - Net Inpatient Revenue	2,841,085	45
46	Medicare - Net Inpatient Revenue	887,273	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,828,796	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? EXTENSION 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Numb Libertyville Manor # 0017780 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

Supplemental Schedule of Revenue as of 12/31/2017

12/31/2017

	Description	Amount
28A	Miscellaneous Revenue - Vending	$ 650
28B	Miscellaneous Revenue - Other	$ 30,687
28C		$ -
28D		
28E		
28E		
28G		
28H		
28I		
28J		
28K		
28L		
28M		
28N		
28O		
28P		
28Q		
28R		
28S		
28T		
		$ 31,337

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,080	2,080	$ 79,520	$ 38.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,620	3,956	175,863	44.45	3
4	Licensed Practical Nurses	14,686	16,137	428,372	26.55	4
5	CNAs & Orderlies	25,192	26,455	351,307	13.28	5
6	CNA Trainees					6
7	Licensed Therapist	7,630	8,170	262,038	32.07	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,765	1,812	30,383	16.77	9
10	Activity Assistants	3,130	3,203	44,799	13.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,173	2,348	41,963	17.87	13
14	Head Cook	2,080	2,080	49,128	23.62	14
15	Cook Helpers/Assistants	2,080	2,080	18,266	8.78	15
16	Dishwashers	9,325	9,872	77,786	7.88	16
17	Maintenance Workers	6,204	5,817	112,231	19.29	17
18	Housekeepers	5,858	6,362	55,700	8.76	18
19	Laundry	2,352	2,705	23,698	8.76	19
20	Administrator	2,080	2,080	87,554	42.09	20
21	Assistant Administrator	2,080	2,080	87,627	42.13	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	67,353	32.38	23
24	Clerical	2,080	2,080	62,331	29.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,495	101,397	$ 2,055,919 *	$ 20.28	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	96	$ 5,472	01-03	35
36	Medical Director	MONTHLY	6,000	09-03	36
37	Medical Records Consultant	MONTHLY	1,600	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	$ 13,072		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	1,914	161,022	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,914	$ 161,022		53

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN STOKOVICH	ADMIN	50	$ 87,553
MILAN STOKOVICH	ASSIT ADMIN	50	87,627
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,180

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
MARCUM,LLP	ACCOUNTING SERVICE	$ 20,856
CANTATA HEALTH	COMPUTER SERVICE	18,313
GBIT, INC	COMPUTER SERVICE	6,529
Legal Fees	see schedule attached	14,058
PAYROLL SERVICE		4,262
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 64,018

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,906
Unemployment Compensation Insurance	11,752
FICA Taxes	156,435
Employee Health Insurance	94,811
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	34,133
TOTAL (agree to Schedule V, line 22, col.8)	$ 342,037

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	$
Advertising: Employee Recruitment	2,979
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
LICENSE AND PERMITS	2,263
PUBLIC RELATIONS	1,669
Less: Public Relations Expense	(1,669)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,242

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
CONTINUING EDUCATION	180
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 180

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Libertyville Manor # 0017780 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line **N/A**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **173,164**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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? **YES** 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. $ Has any meal income been offset against related costs? **NONE** 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? **NONE**
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? **YES**
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.