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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0012930

Facility Name: Westminster Place

Address: 3200 Grant St (Number) Evanston (City) 60201 (Zip Code)

County: Cook

Telephone Number: (847) 492-4800 **Fax #** (847) 570 -3399

HFS ID Number:

Date of Initial License for Current Owners: 02/20/1967

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deb Freeland **Telephone Number:** 317-569-6230
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 04/01/2012 to 03/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Deb Freeland, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave., Suite 1800
(Telephone) (314) 925-4300 Fax # (314) 925-4350

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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	105	Skilled (SNF)	105	38,325	1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5	51	Sheltered Care (SC)	51	18,615	5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,075	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		23,867	8,092	31,959	8
9	SNF/PED					9
10	ICF		31,609		31,609	10
11	ICF/DD					11
12	SC		13,505		13,505	12
13	DD 16 OR LESS					13
14	TOTALS		68,981	8,092	77,073	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.81%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Physical Therapy, Occupational Therapy, Speech Therapy, Radiology & Pharmacy

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 10/01/1922

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 105 and days of care provided 8,092

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: 03/31/2013 Fiscal Year: 03/31/2013

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	909,918	163,679	(43,530)	1,030,067		1,030,067		1,030,067			1
2	Food Purchase		850,743		850,743		850,743	(730,716)	120,027			2
3	Housekeeping	309,237	41,959	145,205	496,401		496,401		496,401			3
4	Laundry	58,835	32,373	19,892	111,100		111,100		111,100			4
5	Heat and Other Utilities			385,331	385,331		385,331	(47,767)	337,564			5
6	Maintenance	372,402	70,099	325,118	767,619		767,619		767,619			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,650,392	1,158,853	832,016	3,641,261		3,641,261	(778,483)	2,862,778			8
	B. Health Care and Programs											
9	Medical Director	367,384			367,384		367,384		367,384			9
10	Nursing and Medical Records	7,652,068	467,271	1,632,258	9,751,597		9,751,597	(97,798)	9,653,799			10
10a	Therapy											10a
11	Activities	289,094	13,157	33,479	335,730		335,730		335,730			11
12	Social Services	153,239	206	312	153,757		153,757		153,757			12
13	CNA Training											13
14	Program Transportation	82,560	1,977		84,537		84,537		84,537			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	8,544,345	482,611	1,666,049	10,693,005		10,693,005	(97,798)	10,595,207			16
	C. General Administration											
17	Administrative	390,097	325	108,285	498,707		498,707	(84,469)	414,238			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			474,098	474,098		474,098		474,098			20
21	Clerical & General Office Expenses	189,732	94,959	402	285,093		285,093		285,093			21
22	Employee Benefits & Payroll Taxes			1,446,368	1,446,368		1,446,368		1,446,368			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,096	15,096		15,096		15,096			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			300,015	300,015		300,015		300,015			26
27	Other (specify):*											27
28	**TOTAL General Administration**	579,829	95,284	2,344,264	3,019,377		3,019,377	(84,469)	2,934,908			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	10,774,566	1,736,748	4,842,329	17,353,643		17,353,643	(960,750)	16,392,893			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 Westminster Place #0012930 **Report Period Beginning:** 04/01/2012 **Ending:** 03/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			864,000	864,000		864,000		864,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			864,000	864,000		864,000		864,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	511,163	5,815	95,129	612,107		612,107		612,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			450,000	450,000		450,000		450,000			42
43	Other (specify):* AL/IL/Marketing/I	6,564,014	520,309	14,650,911	21,735,234		21,735,234	(21,735,234)				43
44	**TOTAL Special Cost Centers**	7,075,177	526,124	15,196,040	22,797,341		22,797,341	(21,735,234)	1,062,107			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,849,743	2,262,872	20,902,369	41,014,984		41,014,984	(22,695,984)	18,319,000			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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	(730,716)	2		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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				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 Attached**				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (730,716)		$	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))**	$ (730,716)		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

Westminster Place

ID# 0012930

Report Period Beginning: 04/01/2012

Ending: 03/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL Salaries	$ (3,203,819)	43	1
2	IL Salaries	(3,178,900)	43	2
3	Marketing Salaries	(90,568)	43	3
4	Fitness Salaries	(84,438)	43	4
5	Beauty Shop Salaries	(6,289)	43	5
6	AL Supplies	(181,078)	43	6
7	IL Supplies	(338,391)	43	7
8	Marketing Supplies	(318)	43	8
9	Fitness Supplies	(522)	43	9
10	AL Other	(4,615,102)	43	10
11	IL Other	(9,991,356)	43	11
12	Marketing Other	(31,666)	43	12
13	Fitness Other	(12,787)	43	13
14	Telephone	(47,767)	05	14
15	Marketing Corporate	(84,469)	17	15
16	Miscellaneous Income	(97,798)	10	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**	(21,965,268)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place # 0012930 **Report Period Beginning:** 04/01/2012 **Ending:** 03/31/2013

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	(730,716)	0	0	0	0	0	0	0	0	0	0	(730,716)	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	(47,767)	0	0	0	0	0	0	0	0	0	0	(47,767)	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**	(778,483)	0	0	0	0	0	0	0	0	0	0	(778,483)	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	(97,798)	0	0	0	0	0	0	0	0	0	0	(97,798)	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**	(97,798)	0	0	0	0	0	0	0	0	0	0	(97,798)	16
	C. General Administration													
17	Administrative	(84,469)	0	0	0	0	0	0	0	0	0	0	(84,469)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(84,469)	0	0	0	0	0	0	0	0	0	0	(84,469)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(960,750)	0	0	0	0	0	0	0	0	0	0	(960,750)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westminster Place **#** 0012930 **Report Period Beginning:** 04/01/2012 **Ending:** 03/31/2013

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(21,735,234)	0	0	0	0	0	0	0	0	0	0	(21,735,234)	43
44	**TOTAL Special Cost Centers**	(21,735,234)	0	0	0	0	0	0	0	0	0	0	(21,735,234)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,695,984)	0	0	0	0	0	0	0	0	0	0	(22,695,984)	45

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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 Supplement	100%	See Page 6 Supplement		See Page 6 Supplement		

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

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

1 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.**

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	See Attached Board of Directors		Balmoral Care Center	Lake Forest	Presbyterian Homes	Evanston	Home Health	1
2			James C. King Home	Evanston				2
3			Mooring Health Center	Arlington Heights				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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

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

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 3/31/2013

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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 Westminster Place **#** 0012930 **Report Period Beginning:** 04/01/2012 **Ending:** 03/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2008	8
	2009	9
	2010	10
	2011	11
	2012	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westminster Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012930

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 116,225 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living

Independent Living

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 251,640	1
2					2
3	TOTALS			$ 251,640	3

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	111			1967	$ 8,547,976	$	50	$ 864,000	$ 864,000	$ 15,965,271	4
5	99			1990	14,003,079		50				5
6	51			1992	2,177,037		50				6
7											7
8											8
	Improvement Type**										
9	Various			2008	903,842		20				9
10	City of Evanston			2009	489		20				10
11	Duncan Carpet Company			2009	21701		20				11
12	Elderlife Development			2009	4665		20				12
13	Executive Construction			2009	21987		20				13
14	Facilities Mgmt Reclass			2009	19385		20				14
15	Hr Decorating, Inc			2009	312		20				15
16	Insolar Window Treatments			2009	2110		20				16
17	Jensen & Halstead Ltd.			2009	8267		20				17
18	Mr. David's Carpet Service			2009	8653		20				18
19	New Vision Technologies			2009	155		20				19
20	Otis Koglin Wilson Architect			2009	162		20				20
21	Quality Plus Flooring			2009	628		20				21
22	Resident Upgrade Act Inv			2009	-31279		20				22
23	Resident Upgrade Act Inv			2009	-22181		20				23
24	Shine on Window Cleaning			2009	330		20				24
25	Specialty Products & Insu			2009	400		20				25
26	Studio One Design			2009	3483		20				26
27	Turn Key Construction			2009	8821		20				27
28	Turn Key Construction			2009	900		20				28
29	Turn Key Construction			2009	9720		20				29
30	W.E. O'Neil			2009	415169		20				30
31	Facility Allocation			2009	3441		20				31
32	Facility Allocation			2009	3019		20				32
33	Facility Allocation			2009	2504		20				33
34	Facility Allocation			2009	1975		20				34
35	Fiscal 2010 Adds Thru October			2009	51068		20				35
36	Fiscal 2010 Adds Thru October			2009	14400		20				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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	Fiscal 2010 Adds Thru October	2009	$ 34688	$	20	$	$	$	37
38	Fiscal 2010 Adds Thru October	2009	16948		20				38
39	Fiscal 2010 Adds Thru October	2009	21244		20				39
40	Insolar Window Treatments	2009	2458		20				40
41	Quality Plus Flooring Inc	2009	559		20				41
42	Turn Key Construction, Inc.	2009	9887		20				42
43	Fiscal 2010 Adds Thru October	2009	79463		20				43
44	Duncan Carpet Company Inc.	2010	3322		20				44
45	Facility Allocation	2010	2589		20				45
46	Facility Allocation	2010	3075		20				46
47	Facility Allocation	2010	446		20				47
48	Facility Allocation	2010	2605		20				48
49	Facility Allocation	2010	226		20				49
50	Facility Allocation	2010	1738		20				50
51	Hr Decorating Inc.	2010	948		20				51
52	Insolar Window Treatments	2010	2076		20				52
53	Otis Elevator Company	2010	8595		20				53
54	Pinnacle Services, Inc.	2010	5116		20				54
55	Quality Plus Flooring Inc.	2010	617		20				55
56	Steve Works	2010	58		20				56
57	Turn Key Construction, Inc.	2010	158		20				57
58	Wiss Janney Elstner Associates	2010	3744		20				58
59	W.L. Kercher Co.	2010	9175		20				59
60	Facility Allocation	2010	1905		20				60
61	Facility Allocation	2010	696		20				61
62	Facility Allocation	2010	1614		20				62
63	Facility Allocation	2010	353		20				63
64	Assisted Living Renovation	2010	3840		20				64
65	Chapel Entrance Carpet	2010	588		20				65
66	Contingency -Securtity Doors & Locks	2010	13540		20				66
67	Fountain Restoration-Huss	2010	1782		20				67
68	Highlands Apartment Redecoration	2010	15639		20				68
69	Living Redecorations	2010	787		20				69
70	TOTAL (lines 4 thru 69)		$ 26,432,697	$		$ 864,000	$ 864,000	$ 15,965,271	70

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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		$ 26,432,697	$		$ 864,000	$ 864,000	$ 15,965,271	1
2	New Standard-Redecoration	2010	9390		20				2
3	Old Standard Redecoration	2010	36319		20				3
4	Replace Obsolete Fire Detectors	2010	2510		20				4
5	Sprinkler System	2010	14980		20				5
6	Tile	2010	656		20				6
7	Tuckpointing	2010	135922		20				7
8	Window Replacement	2010	1831		20				8
9	Asphalt & Concrete Repair	2011	3552		20				9
10	Contingency- Plumbing Water Main Repair	2011	6530		20				10
11	Contingency- Plumbing Water Main Repair	2011	4315		20				11
12	Flooring	2011	645		20				12
13	Fountain Restoration-Huss	2011	13952		20				13
14	Genva Place Entrance Door Replacement	2011	7997		20				14
15	Highlands Apartment Redecoration	2011	2989		20				15
16	McGaw North-Piping, Gaskets Converter System	2011	6621		20				16
17	Miscellaneous Improvements	2011	-1400		20				17
18	New Standard Redecoration	2011	577		20				18
19	Old Standard Redecoration	2011	12181		20				19
20	Plumbing Repair Broken Water main McGaw	2011	15516		20				20
21	Replace Stereos Foster	2011	1267		20				21
22	Weather Protection	2011	1364		20				22
23	Assisted Living Renovations 5@ $24,000	2011	12867		20				23
24	Assisted Living Unit Turnovers	2011	65945		20				24
25	Highlands Apartment Renovations - Carpet & Labor	2011	5860		20				25
26	Tuckpointing - Chapel & C Wing	2011	9576		20				26
27	Huss Fountain Pool	2011	40471		20				27
28	Huss Fountain Repair or Replacement	2011	42231		20				28
29	Renovate Huss Fountain	2011	4279		20				29
30	Replace Sidwell Multizone Airhandler	2011	13792		20				30
31	Tuckpointing	2011	7073		20				31
32	Wm Contingency Sidwell Roof	2011	13557		20				32
33	Patient Bathrooms - Biospec Sheet Vinyl Flr & Base	2011	43022		20				33
34	TOTAL (lines 1 thru 33)		$ 26,969,084	$		$ 864,000	$ 864,000	$ 15,965,271	34

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 26,969,084	$		$ 864,000	$ 864,000	$ 15,965,271	1
2	Front Bldg Renovation, Architect Fees, Engineering	2011	224100		20				2
3	Assisted Living First Floor Ceiling	2012	1200		20				3
4	Assisted Living Unit Turnovers-FM Time	2012	23919		20				4
5	Highlands Apartments Renovations - Carpet & Labor	2012	1317		20				5
6	Replace Sidwell Multizone Airhandler	2012	35580		20				6
7	Interior Design Associates Inc.	2012	10478		20				7
8	Patient Bathrooms- Biospec Sheet Vinyl Flr and Base	2012	25462		20				8
9	Front Bldg Renovation, Architect Fees, Engineering, Landscape	2012	121126		20				9
10	Project Manager Salary Costs	2012	23914		20				10
11	GREENLEAF CABINETS, INC.	2013	30,610		20				11
12	PINNACLE SERVICES INC	2012	8,376		20				12
13	STAIR ONE, INC.	2012	17,500		20				13
14	GREENLEAF CABINETS, INC.	2013	36,960		20				14
15	GREENLEAF CABINETS, INC.	2013	20,160		20				15
16	GREENLEAF CABINETS, INC.	2013	53,760		20				16
17	Facility Allocation	2012	165		20				17
18	Facility Allocation	2012	1,902		20				18
19	Facility Allocation	2012	895		20				19
20	Facility Allocation	2012	1,683		20				20
21	Facility Allocation	2012	856		20				21
22	Facility Allocation	2012	1,683		20				22
23	Facility Allocation	2012	1,787		20				23
24	Facility Allocation	2013	2,469		20				24
25	Facility Allocation	2013	1,808		20				25
26	Facility Allocation	2013	122		20				26
27	POWER CONSTRUCTION	2013	130,000		20				27
28	POWER CONSTRUCTION	2013	464,000		20				28
29	OTIS KOGLIN WILSON ARCHITECTS INC	2013	42,800		20				29
30	POWER CONSTRUCTION	2013	381,553		20				30
31	POWER CONSTRUCTION	2013	518,180		20				31
32	POWER CONSTRUCTION	2013	408,317		20				32
33	POWER CONSTRUCTION	2013	346,748		20				33
34	TOTAL (lines 1 thru 33)		$ 29,908,514	$		$ 864,000	$ 864,000	$ 15,965,271	34

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 29,908,514	$		$ 864,000	$ 864,000	$ 15,965,271	1
2	POWER CONSTRUCTION	2013	26,201		20				2
3	INTERIOR DESIGN ASSOCIATES INC	2013	2,500		20				3
4	INTERIOR DESIGN ASSOCIATES INC	2013	2,629		20				4
5	INTERIOR DESIGN ASSOCIATES INC	2013	3,194		20				5
6	INTERIOR DESIGN ASSOCIATES INC	2013	2,629		20				6
7	INTERIOR DESIGN ASSOCIATES INC	2013	3,459		20				7
8	INTERIOR DESIGN ASSOCIATES INC	2013	57,326		20				8
9	LAKOTA GROUP	2013	6,830		20				9
10	Power Construction Company	2013	495,893		20				10
11	ERIKSSON ENGINEERING ASSOC LTD.	2013	1,240		20				11
12	INTERIOR DESIGN ASSOCIATES INC	2013	3,630		20				12
13	OKW Architects, Inc.	2013	6,405		20				13
14	Power Construction Company	2013	678,275		20				14
15	ERIKSSON ENGINEERING ASSOC LTD.	2013	499		20				15
16	LAKOTA GROUP	2013	1,893		20				16
17	INTERIOR DESIGN ASSOCIATES INC	2013	4,443		20				17
18	ELDERLIFE DEVELOPMENT LTD	2013	3,818		20				18
19	OTIS KOGLIN WILSON ARCHITECTS INC	2013	8,264		20				19
20	Pinnacle Services Inc	2013	985		20				20
21	ERIKSSON ENGINEERING ASSOC LTD.	2013	3,986		20				21
22	ERIKSSON ENGINEERING ASSOC LTD.	2013	4,450		20				22
23	ERIKSSON ENGINEERING ASSOC LTD.	2013	57		20				23
24	OTIS KOGLIN WILSON ARCHITECTS INC	2013	1,387		20				24
25	INTERIOR DESIGN ASSOCIATES INC	2013	951		20				25
26	TESTING SERVICE CORPORATION	2013	4,139		20				26
27	Burnham Nationwide, Inc.	2013	2,776		20				27
28	ERIKSSON ENGINEERING ASSOC LTD.	2013	85		20				28
29	INTERIOR DESIGN ASSOCIATES INC	2013	57,740		20				29
30	ERIKSSON ENGINEERING ASSOC LTD.	2013	1,301		20				30
31	TESTING SERVICE CORPORATION	2013	5,865		20				31
32	INTERIOR DESIGN ASSOCIATES INC	2013	911		20				32
33	ERIKSSON ENGINEERING ASSOC LTD.	2013	788		20				33
34	**TOTAL (lines 1 thru 33)**		**$ 31,303,063**	**$**		**$ 864,000**	**$ 864,000**	**$ 15,965,271**	34

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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 12D, Carried Forward		$ 31,303,063	$		$ 864,000	$ 864,000	$ 15,965,271	1
2	THE LUSE COMPANIES	2013	5,484		20				2
3	TESTING SERVICE CORPORATION	2013	5,289		20				3
4	Nicor Gas	2013	385		20				4
5	INTERIOR DESIGN ASSOCIATES INC	2013	993		20				5
6	LASALLE ASSOCIATES INC	2013	728		20				6
7	WISS JANNEY ELSTNER ASSOCIATES	2013	1,175		20				7
8	OTIS KOGLIN WILSON ARCHITECTS INC	2013	403		20				8
9	TESTING SERVICE CORPORATION	2013	1,281		20				9
10	GEORGE NELSON	2013	1,315		20				10
11	Burnham Nationwide, Inc.	2013	2,517		20				11
12	OTIS KOGLIN WILSON ARCHITECTS INC	2013	889		20				12
13	TESTING SERVICE CORPORATION	2013	2,881		20				13
14	City of Evanston	2013	678		20				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	Financial Statement Depreciation			864,000			(864,000)		33
34	TOTAL (lines 1 thru 33)		$ 31,327,080	$ 864,000		$ 864,000	$	$ 15,965,271	34

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	$ 4,185,627	$	$	$	10	$	71
72	Current Year Purchases	118,474						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 4,304,101	$	$	$		$	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)	$ 35,882,821	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 864,000	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 864,000	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,965,271	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	Assisted Living	$ 32,604,754	$ 864,000	$ 20,656,748	86
87	Independent Living	91,272,083	339,400	50,036,833	87
88					88
89					89
90					90
91	TOTALS	$ 123,876,837	$ 1,203,400	$ 70,693,581	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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.	/2014	$
13.	/2015	$
14.	/2016	$

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 Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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.

   Westminster Place only hires CNAs that are already certified.

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.

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	$	181,605		$ 144,578	$		$ 326,183	1
2	Licensed Speech and Language Development Therapist	39-01	hrs		2,182		1,737			3,919	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-01	hrs		327,376		260,627			588,003	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): Health Pro Management/Medical Supplies						90,644	392,340		482,984	12
13	Other (specify):										13
14	TOTAL			$	511,163		$ 497,586	$ 392,340		$ 1,401,089	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.

STATE OF ILLINOIS

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2013 (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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 400,000)	5,137,997		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	7,254,927		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,295,879		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	(2,687,761)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,001,042	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	100,320		11
12	Long-Term Investments	118,857,755		12
13	Land	28,458,621		13
14	Buildings, at Historical Cost	359,023,993		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	45,361,013		16
17	Accumulated Depreciation (book methods)	(178,574,257)		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 (spe SEE ATTACHED	5,073,533		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378,300,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 389,302,020	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,793,269	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,685,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	391,008		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED	9,968,371		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 22,837,648	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	66,100,000		39
40	Mortgage Payable			40
41	Bonds Payable	46,020,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED	215,459,707		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 327,579,707	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 350,417,355	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 38,884,665	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 389,302,020	$	48

*(See instructions.)

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 41,452,686	1
2	Restatements (describe):		2
3	**Net Income Reconciliation to consolidated Balance Sheet**	(6,627,532)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 34,825,154	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,059,511	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)**	$ 4,059,511	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)**	$ 38,884,665	24 *

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	$ 16,104,617	1
2	Discounts and Allowances for all Levels	(860,029)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,244,588	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,755,423	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,755,423	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	60,883	12
13	Barber and Beauty Care	303,211	13
14	Non-Patient Meals	730,716	14
15	Telephone, Television and Radio	27,761	15
16	Rental of Facility Space	77,366	16
17	Sale of Drugs	2,131,555	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,240	20
21	Other Medical Services	5,200	21
22	Laundry	2,839	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,340,771	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	53,790	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,790	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHMENT	24,679,923	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,679,923	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 45,074,495	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,641,261	31
32	Health Care	10,693,005	32
33	General Administration	3,019,377	33
	B. Capital Expense		
34	Ownership	864,000	34
	C. Ancillary Expense		
35	Special Cost Centers	22,797,341	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 41,014,984	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,059,511	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,059,511	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue	4,362,645	45
46	Medicare - Net Inpatient Revenue	1,693,605	46
47	Other-(specify) Amortization/Fellowship/Insurance	9,188,338	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,244,588	49

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

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

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

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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	40,613	36,409	$ 1,323,542	$ 36.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	141,233	126,578	2,975,012	23.50	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	130,992	117,902	3,133,109	26.57	5
6	CNA Trainees					6
7	Licensed Therapist	17,203	15,481	508,773	32.86	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,125	11,634	226,789	19.49	10
11	Social Service Workers	8,041	7,193	214,765	29.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	54,172	49,135	672,142	13.68	15
16	Dishwashers					16
17	Maintenance Workers	14,266	12,758	302,147	23.68	17
18	Housekeepers	28,920	25,506	301,825	11.83	18
19	Laundry	5,620	5,230	57,853	11.06	19
20	Administrator	991	910	70,949	77.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,751	14,946	290,085	19.41	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)	10,523	9,693	200,175	20.65	33
34	TOTAL (lines 1 - 33)	482,450	433,375	$ 10,277,166 *	$ 23.71	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,368	20-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Medical Services Con	Monthly	3,042	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,410		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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda L. Dotson	Administrator		$ 132,356
Keith Stohlgren	Director		257,741
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 390,097

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
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 148,093
Unemployment Compensation Insurance	14,650
FICA Taxes	1,523
Employee Health Insurance	1,067,330
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Social Security	732,441
Disability	36,912
Resident Ancillary Charges	(973,204)
Retirement	407,053
Severance	11,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,446,368

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,561
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Licenses & Fees	21,099
Dues & Sbscriptions	19,507
Professional Fees	425,931
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 474,098

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,945
Seminar Expense	11,151
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,096

**See instructions.

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2012 Ending: 03/31/2013

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. **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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** 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. **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. $ **450,000**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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? **Yes**
Firm Name: **CliftonLarsonAllen, LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.