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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0012930

Facility Name: Westminster Place

Address: 3200 Grant Street (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 4/1/2014 to 3/31/2015 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, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 9365 Counselor's Row, Suite 200, Indianapolis, IN 46240
(Telephone) (317) 569-6230 Fax # (317) 574-9707

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: 4/1/2014 Ending: 3/31/2015

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	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	1,410	23,427	7,590	32,427	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	211	29,135		29,346	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,621	52,562	7,590	61,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.37%

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 7,590

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: 3/31/2015 Fiscal Year: 3/31/2015

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	1,371,752	136,509	(39,917)	1,468,344		1,468,344		1,468,344			1
2	Food Purchase		1,047,033		1,047,033		1,047,033	(92,126)	954,907			2
3	Housekeeping	300,441	12,627	160,425	473,493		473,493	(25)	473,468			3
4	Laundry	84,639	22,714	53,783	161,136		161,136		161,136			4
5	Heat and Other Utilities			300,052	300,052		300,052		300,052			5
6	Maintenance	263,158	44,094	383,380	690,632		690,632		690,632			6
7	Other (specify):*											7
8	TOTAL General Services	2,019,990	1,262,977	857,723	4,140,690		4,140,690	(92,151)	4,048,539			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	7,889,286	1,892,498	400,566	10,182,350		10,182,350		10,182,350			10
10a	Therapy											10a
11	Activities	213,134	22,530	18,821	254,485		254,485	(14,136)	240,349			11
12	Social Services	256,781	1,919	10,143	268,843		268,843		268,843			12
13	CNA Training											13
14	Program Transportation	116,522	1,014		117,536		117,536	(709)	116,827			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,475,723	1,917,961	429,530	10,823,214		10,823,214	(14,845)	10,808,369			16
	C. General Administration											
17	Administrative	137,657	2,095	53,302	193,054	(43,810)	149,244	(38,972)	110,272			17
18	Directors Fees											18
19	Professional Services			22,328	22,328		22,328		22,328			19
20	Dues, Fees, Subscriptions & Promotions			83,627	83,627		83,627		83,627			20
21	Clerical & General Office Expenses	67,296	1,169	1,795,014	1,863,479	43,810	1,907,289	(63,918)	1,843,371			21
22	Employee Benefits & Payroll Taxes			2,506,019	2,506,019		2,506,019		2,506,019			22
23	Inservice Training & Education											23
24	Travel and Seminar			40,538	40,538		40,538		40,538			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			138,619	138,619		138,619		138,619			26
27	Other (specify):*											27
28	TOTAL General Administration	204,953	3,264	4,639,447	4,847,664		4,847,664	(102,890)	4,744,774			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,700,666	3,184,202	5,926,700	19,811,568		19,811,568	(209,886)	19,601,682			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:** 4/1/2014 **Ending:** 3/31/2015

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			707,156	707,156		707,156		707,156			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**			707,156	707,156		707,156		707,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	867,625	8,450	150,653	1,026,728		1,026,728		1,026,728			39
40	Barber and Beauty Shops			887	887		887		887			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			436,484	436,484		436,484		436,484			42
43	Other (specify):* AL/IL/Marketing	5,602,983	454,204	14,726,851	20,784,038		20,784,038	(20,784,038)				43
44	**TOTAL Special Cost Centers**	6,470,608	462,654	15,314,875	22,248,137		22,248,137	(20,784,038)	1,464,099			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,171,274	3,646,856	21,948,731	42,766,861		42,766,861	(20,993,924)	21,772,937			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: 4/1/2014 Ending: 3/31/2015

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	(85,026)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(71)	14		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	(63,918)	21		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	(20,844,909)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,993,924)		$	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))**	$ (20,993,924)		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: 4/1/2014

Ending: 3/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL Salaries	$ (2,391,142)	43	1
2	IL Salaries	(3,214,472)	43	2
3	Fitness Salaries	2,352	43	3
4	Beauty Shop Salaries	279	43	4
5	AL Supplies	(128,477)	43	5
6	IL Supplies	(325,722)	43	6
7	Marketing Supplies	(5)	43	7
8	AL Other	(4,136,572)	43	8
9	IL Other	(10,563,770)	43	9
10	Marketing Other	(26,662)	43	10
11	Fitness Other	153	43	11
12	IL Real Estate Tax	(38,972)	17	12
13	Resident Catering	(6,614)	2	13
14	Liquor	(486)	2	14
15	Housekeeping	(25)	3	15
16	Bus Rental	(638)	14	16
17	Event Revenue	(7,855)	11	17
18	Craft Sales	(6,281)	11	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**	(20,844,909)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place # 0012930 **Report Period Beginning:** 4/1/2014 **Ending:** 3/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(92,126)	0	0	0	0	0	0	0	0	0	0	(92,126)	2
3	Housekeeping	(25)	0	0	0	0	0	0	0	0	0	0	(25)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(92,151)	0	0	0	0	0	0	0	0	0	0	(92,151)	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	(14,136)	0	0	0	0	0	0	0	0	0	0	(14,136)	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	(709)	0	0	0	0	0	0	0	0	0	0	(709)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(14,845)	0	0	0	0	0	0	0	0	0	0	(14,845)	16
	C. General Administration													
17	Administrative	(38,972)	0	0	0	0	0	0	0	0	0	0	(38,972)	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	(63,918)	0	0	0	0	0	0	0	0	0	0	(63,918)	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**	(102,890)	0	0	0	0	0	0	0	0	0	0	(102,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(209,886)	0	0	0	0	0	0	0	0	0	0	(209,886)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westminster Place **#** 0012930 **Report Period Beginning:** 4/1/2014 **Ending:** 3/31/2015

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):*	(20,784,038)	0	0	0	0	0	0	0	0	0	0	(20,784,038)	43
44	**TOTAL Special Cost Centers**	(20,784,038)	0	0	0	0	0	0	0	0	0	0	(20,784,038)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,993,924)	0	0	0	0	0	0	0	0	0	0	(20,993,924)	45

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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 attached listing		Balmoral Care Center	Lake Forest			
		James C. King Home	Evanston			
		Moorings Health Center	Arlington Heights			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Management Fee	$ 1,610,036	Presbyterian Homes Corporate	0.00%	$ 1,610,036	$	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			$ 1,610,036			$ 1,610,036	$ *	14

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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: 4/1/2014 Ending: 3/31/2015

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: 4/1/2014 Ending: 3/31/2015

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:** 4/1/2014 **Ending:** 3/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
2010		8
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 4/1/2014 Ending: 3/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 125,319 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Three

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			$ 8,252	1
2					2
3	TOTALS			$ 8,252	3

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Fixed Assets			1979	1,796,483						9
10	1985 Fixed Assets			1985	1,210						10
11	1989 Fixed Assets			1989	17,483						11
12	1990 Fixed Assets			1990	7,609,113						12
13	1991 Fixed Assets			1991	323,208						13
14	1992 Fixed Assets			1992	318,137						14
15	1993 Fixed Assets			1993	66,971						15
16	1994 Fixed Assets			1994	32,165						16
17	1995 Fixed Assets			1995	497,218						17
18	1996 Fixed Assets			1996	234,301						18
19	1997 Fixed Assets			1997	27,890						19
20	1998 Fixed Assets			1998	89,419						20
21	1999 Fixed Assets			1999	116,031						21
22	2000 Fixed Assets			2000	684,998						22
23	2001 Fixed Assets			2001	2,274,323						23
24	2002 Fixed Assets			2002	261,032						24
25	2003 Fixed Assets			2003	279,274						25
26	2004 Fixed Assets			2004	298,261						26
27	2005 Fixed Assets			2005	1,065,345						27
28	2006 Fixed Assets			2006	1,216,099						28
29	2007 Fixed Assets			2007	437,642						29
30	2008 Fixed Assets			2008	198,335						30
31	2009 Fixed Assets			2009	1,052,485						31
32	W.L.KERCHER CO.			2010	9,175						32
33	THE BOELTER COMPANIES, INC.			2011	1,900						33
34	DALLIA FLOOR & WALL CO. INC.			2011	9,658						34
35	DALLIA FLOOR & WALL CO. INC.			2011	7,024						35
36	OTIS KOGLIN WILSON ARCHITECTS INC.			2011	71,611						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: 4/1/2014 Ending: 3/31/2015

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	OTIS KOGLIN WILSON ARCHITECTS INC.	2011	$ 9,589	$		$	$	$	37
38	OTIS KOGLIN WILSON ARCHITECTS INC	2011	17,850						38
39	DALLIA FLOOR & WALL CO INC	2011	8,780						39
40	TESTING SERVICE CORPORATION	2011	4,156						40
41	ERIKSSON ENGINEERING ASSOC LTD.	2011	18,190						41
42	INTERIOR DESIGN ASSOCIATES INC	2011	2,500						42
43	OTIS KOGLIN WILSON ARCHITECTS INC	2011	44,566						43
44	DALLIA FLOOR & WALL CO INC	2011	17,560						44
45	BOELTER COMPANIES CORPORATE OFFICE	2011	6,000						45
46	OTIS KOGLIN WILSON ARCHITECTS INC	2011	37,289						46
47	INTERIOR DESIGN ASSOCIATES INC	2011	7,500						47
48	ILLINOIS DEPARTMENT OF PUBLIC HEALTH PLA	2011	9,600						48
49	TESTING SERVICE CORPORATION	2011	1,250						49
50	DALLIA FLOOR & WALL CO INC	2012	10,536						50
51	Metropolitan Water Reclamation	2012	4,000						51
52	INTERIOR DESIGN ASSOCIATES INC	2012	12,387						52
53	ERIKSSON ENGINEERING ASSOC LTD.	2012	7,012						53
54	ERIKSSON ENGINEERING ASSOC LTD.	2012	510						54
55	LAKOTA GROUP	2012	30,056						55
56	OTIS KOGLIN WILSON ARCHITECTS INC	2012	9,903						56
57	OTIS KOGLIN WILSON ARCHITECTS INC	2012	45,510						57
58	ERIKSSON ENGINEERING ASSOC LTD.	2012	122						58
59	ILLINOIS DEPARTMENT OF PUBLIC HEALTH PLA	2012	9,600						59
60	DALLIA FLOOR & WALL CO INC	2012	14,926						60
61	INTERIOR DESIGN ASSOCIATES INC	2012	2,026						61
62	ELDERLIFE DEVELOPMENT LTD	2012	3,818						62
63	OTIS KOGLIN WILSON ARCHITECTS INC	2012	8,264						63
64	Pinnacle Services Inc	2012	985						64
65	ERIKSSON ENGINEERING ASSOC LTD.	2012	3,986						65
66	ERIKSSON ENGINEERING ASSOC LTD.	2012	4,450						66
67	ERIKSSON ENGINEERING ASSOC LTD.	2012	57						67
68	OTIS KOGLIN WILSON ARCHITECTS INC	2012	1,387						68
69	INTERIOR DESIGN ASSOCIATES INC	2012	951						69
70	TOTAL (lines 4 thru 69)		$ 19,352,106	$		$	$	$	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: 4/1/2014 Ending: 3/31/2015

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		$ 19,352,106	$		$	$	$	1
2	TESTING SERVICE CORPORATION	2012	4,139						2
3	Burnham Nationwide, Inc.	2012	2,776						3
4	ERIKSSON ENGINEERING ASSOC LTD.	2012	85						4
5	INTERIOR DESIGN ASSOCIATES INC	2012	57,740						5
6	ERIKSSON ENGINEERING ASSOC LTD.	2012	1,301						6
7	TESTING SERVICE CORPORATION	2012	5,865						7
8	INTERIOR DESIGN ASSOCIATES INC	2012	911						8
9	ERIKSSON ENGINEERING ASSOC LTD.	2012	788						9
10	THE LUSE COMPANIES	2012	5,484						10
11	TESTING SERVICE CORPORATION	2012	5,289						11
12	Nicor Gas	2012	385						12
13	INTERIOR DESIGN ASSOCIATES INC	2012	993						13
14	LASALLE ASSOCIATES INC	2012	728						14
15	WISS JANNEY ELSTNER ASSOCIATES	2012	1,175						15
16	OTIS KOGLIN WILSON ARCHITECTS INC	2012	403						16
17	TESTING SERVICE CORPORATION	2012	1,281						17
18	GEORGE NELSON	2012	1,315						18
19	PINNACLE SERVICES INC	2012	8,376						19
20	STAIR ONE, INC.	2012	17,500						20
21	Burnham Nationwide, Inc.	2012	2,517						21
22	OTIS KOGLIN WILSON ARCHITECTS INC	2012	889						22
23	TESTING SERVICE CORPORATION	2012	2,881						23
24	City of Evanston	2012	678						24
25	GREENLEAF CABINETS, INC.	2013	36,960						25
26	OTIS KOGLIN WILSON ARCHITECTS INC	2013	42,800						26
27	POWER CONSTRUCTION	2013	381,553						27
28	POWER CONSTRUCTION	2013	518,180						28
29	POWER CONSTRUCTION	2013	408,317						29
30	POWER CONSTRUCTION	2013	346,748						30
31	POWER CONSTRUCTION	2013	26,201						31
32	POWER CONSTRUCTION	2013	464,000						32
33	POWER CONSTRUCTION	2013	130,000						33
34	TOTAL (lines 1 thru 33)		$ 21,830,364	$		$	$	$	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: 4/1/2014 Ending: 3/31/2015

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		$ 21,830,364	$		$	$	$	1
2	INTERIOR DESIGN ASSOCIATES INC	2013	2,500						2
3	GREENLEAF CABINETS, INC.	2013	30,610						3
4	GREENLEAF CABINETS, INC.	2013	20,160						4
5	GREENLEAF CABINETS, INC.	2013	53,760						5
6	INTERIOR DESIGN ASSOCIATES INC	2013	2,629						6
7	INTERIOR DESIGN ASSOCIATES INC	2013	3,194						7
8	INTERIOR DESIGN ASSOCIATES INC	2013	2,629						8
9	INTERIOR DESIGN ASSOCIATES INC	2013	3,459						9
10	INTERIOR DESIGN ASSOCIATES INC	2013	57,326						10
11	LAKOTA GROUP	2013	6,830						11
12	Power Construction Company	2013	495,893						12
13	ERIKSSON ENGINEERING ASSOC LTD.	2013	1,240						13
14	INTERIOR DESIGN ASSOCIATES INC	2013	3,630						14
15	OKW Architects, Inc.	2013	6,405						15
16	Power Construction Company	2013	678,275						16
17	ERIKSSON ENGINEERING ASSOC LTD.	2013	499						17
18	LAKOTA GROUP	2013	1,893						18
19	INTERIOR DESIGN ASSOCIATES INC	2013	4,443						19
20	Otis,Koglin, Wilson 32226	2013	41,200						20
21	Otis,Koglin, Wilson 32229	2013	67,660						21
22	Otis,Koglin, Wilson 32228	2013	5,940						22
23	Interior Design Assoc 23605	2013	65,045						23
24	LAKOTA GROUP	2013	4,996						24
25	F E MORAN INC	2013	17,475						25
26	PINNACLE SERVICES INC	2013	3,967						26
27	Eriksson Engineering Assoc	2013	753						27
28	Power Construction Company	2013	109,273						28
29	THE STATE FIRE MARSHALL	2013	30						29
30	OKW ARCHITECTS INC	2013	1,416						30
31	ATOMATIC MECHANICAL	2014	23,547						31
32	2014 Various	2014	80,300						32
33	McGaw- Mold Remediation	2015	61,764						33
34	TOTAL (lines 1 thru 33)		$ 23,689,105	$		$	$	$	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: 4/1/2014 Ending: 3/31/2015

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		$ 23,689,105	$		$	$	$	1
2	McGaw- Mold Remediation	2015	271,860						2
3	WM Contingency Roam Alert McGaw	2015	13,825						3
4	WM Contingency Roam Alert McGaw	2015	14,076						4
5									5
6	Financial Statement Depreciation			601,716		601,716		13,282,273	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	TOTAL (lines 1 thru 33)		$ 23,988,866	$ 601,716		$ 601,716	$	$ 13,282,273	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: 4/1/2014 Ending: 3/31/2015

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	$ 4,389,582	$	$	$		$	71
72	Current Year Purchases	74,674						72
73	Fully Depreciated Assets							73
74	Financial Statement Depreciation		105,440	105,440			4,198,842	74
75	TOTALS	$ 4,464,256	$ 105,440	$ 105,440	$		$ 4,198,842	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)	$ 28,461,374	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 707,156	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 707,156	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)	$ 17,481,115	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	AL	$ 32,477,242	$ 965,402	$ 22,640,256	86
87	IL	102,988,483	4,372,557	58,157,998	87
88					88
89					89
90					90
91	TOTALS	$ 135,465,725	$ 5,337,959	$ 80,798,254	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: 4/1/2014 Ending: 3/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 4/1/2014 Ending: 3/31/2015

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 hires certified CNAs.

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: 4/1/2014 Ending: 3/31/2015

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	7972	hrs	$ 295,933		$	$	7,972	$ 295,933	1
2	Licensed Speech and Language Development Therapist	39-1	1212	hrs	48,369	38	2,570		1,250	50,939	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39-1	13699	hrs	523,323	691	43,605		14,390	566,928	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): Mgmt Fees	39-3					61,125			61,125	12
13	Other (specify):										13
14	TOTAL				$ 867,625	729	$ 107,300	$	23,612	$ 974,925	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: 4/1/2014 Ending: 3/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/2015 (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	$ 10,694,285	$	1
2	Cash-Patient Deposits	1,825,011		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 473,000)	3,796,338		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,631,354		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,115,274		7
8	Accounts Receivable (owners or related parties)	1,353,505		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 20,415,767	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	121,908,810		12
13	Land	32,467,295		13
14	Buildings, at Historical Cost	395,508,411		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,358,097		16
17	Accumulated Depreciation (book methods)	(210,015,786)		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): Attached	6,439,690		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 397,666,517	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 418,082,284	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,865,434	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,935,000		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	383,647		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached	7,999,723		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 25,183,804	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	61,600,000		39
40	Mortgage Payable			40
41	Bonds Payable	42,815,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	10,145,847		43
44	Apt & Congregate	244,023,144		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 358,583,991	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 383,767,795	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 34,314,489	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 418,082,284	$	48

*(See instructions.)

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 178,373,547	1
2	Restatements (describe):		2
3	**Net Income Reconciliation to Consolidated Balance Sheet**	(149,249,501)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 29,124,046	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,190,443	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)**	$ 5,190,443	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)**	$ 34,314,489	24 *

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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	$ 18,738,052	1
2	Discounts and Allowances for all Levels	(5,413,891)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,324,161	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,148,604	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,148,604	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	69,129	12
13	Barber and Beauty Care	271,968	13
14	Non-Patient Meals	1,501,800	14
15	Telephone, Television and Radio	525	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,504,758	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,939	19
20	Radiology and X-Ray	(122)	20
21	Other Medical Services	29,091	21
22	Laundry	(54)	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,388,034	23
	D. Non-Operating Revenue		
24	Contributions	3,236,863	24
25	Interest and Other Investment Income***	318,135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,554,998	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL/Miscellaneous	24,541,507	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,541,507	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 47,957,304	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,140,690	31
32	Health Care	10,823,214	32
33	General Administration	4,847,664	33
	B. Capital Expense		
34	Ownership	707,156	34
	C. Ancillary Expense		
35	Special Cost Centers	22,248,137	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)***	$ 42,766,861	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,190,443	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,190,443	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 518,339	44
45	Private Pay - Net Inpatient Revenue	11,142,374	45
46	Medicare - Net Inpatient Revenue	1,663,448	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,324,161	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: 4/1/2014 Ending: 3/31/2015

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	6,847	7,754	$ 494,023	$ 63.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	70,173	70,173	2,834,446	40.39	3
4	Licensed Practical Nurses	9,187	9,187	284,372	30.95	4
5	CNAs & Orderlies	162,099	162,099	2,673,824	16.50	5
6	CNA Trainees					6
7	Licensed Therapist	20,561	22,721	861,482	37.92	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	44,220	48,552	822,424	16.94	10
11	Social Service Workers	17,827	19,069	565,168	29.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	63,822	70,512	1,576,400	22.36	15
16	Dishwashers					16
17	Maintenance Workers	62,992	68,902	1,389,120	20.16	17
18	Housekeepers	76,399	85,780	884,366	10.31	18
19	Laundry	9,868	10,811	117,789	10.90	19
20	Administrator	29,182	32,447	1,276,902	39.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	28,363	31,073	1,075,689	34.62	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 C: Pharmacy	11,443	12,451	461,633	37.08	32
33	Other(specify) Dining/Clinic	109,543	118,750	1,853,636	15.61	33
34	TOTAL (lines 1 - 33)	722,526	770,281	$ 17,171,274 *	$ 22.29	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	15,525	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,201	$ 75,422	10-3	50
51	Licensed Practical Nurses	131	5,687	10-3	51
52	Certified Nurse Assistants/Aides	2,498	57,966	10-3	52
53	TOTAL (lines 50 - 52)	3,830	$ 139,075		53

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Stohlgren	VP Executive Director		$ 93,847
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,847

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
Gould & Ratner	Legal	$ 22,311
Federal Express	Legal	17
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,328

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,935
Unemployment Compensation Insurance	
FICA Taxes	799,814
Employee Health Insurance	1,222,115
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,946
Retirement	361,070
Disability	34,139
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,506,019

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	25,416
Licenses and Fees	19,462
Professional Fees	38,202
Recruiting	547
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 83,627

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	1,006
Seminar Expense	39,532
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 40,538

**See instructions.

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2014 Ending: 3/31/2015

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.

(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. $ **436,484**
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? **Yes** Indicate the amount. $ **85,026**

(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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen LLP**

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

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