FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 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:

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

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2015 to 3/31/2016 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) Mark Havrilka

(Title) Chief Financial Officer

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

In the event there are further questions about this report, please contact:
Name: Deb Freeland Telephone Number: (317) 569-6230
Email Address:

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: 4/1/2015 Ending: 3/31/2016

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,430	1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,234	3
4		Intermediate/DD			4
5	51	Sheltered Care (SC)	51	18,666	5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,330	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	952	20,472	8,452	29,876	8
9	SNF/PED					9
10	ICF		24,297		24,297	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	952	44,769	8,452	54,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.04%

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 [X] NO [ ]

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 8,452

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: 3/31/2016 Fiscal Year: 3/31/2016

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	806,767	13,453	1,459,417	2,279,637		2,279,637		2,279,637			1
2	Food Purchase		88,733		88,733		88,733	(28,721)	60,012			2
3	Housekeeping	311,481	2,197	171,903	485,581		485,581	(570)	485,011			3
4	Laundry	91,281	21,139	25,852	138,272		138,272		138,272			4
5	Heat and Other Utilities			245,741	245,741		245,741		245,741			5
6	Maintenance	264,915	40,063	375,622	680,600		680,600		680,600			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,474,444	165,585	2,278,535	3,918,564		3,918,564	(29,291)	3,889,273			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	7,263,531	354,206	78,783	7,696,520		7,696,520		7,696,520			10
10a	Therapy											10a
11	Activities	255,216	10,734	32,718	298,668		298,668	(14,999)	283,669			11
12	Social Services	245,966	3,174	24,403	273,543		273,543		273,543			12
13	CNA Training											13
14	Program Transportation	110,421	1,177		111,598		111,598	(4,530)	107,068			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,875,134	369,291	135,904	8,380,329		8,380,329	(19,529)	8,360,800			16
	C. General Administration											
17	Administrative	127,856	1,387	1,788,090	1,917,333	(32,306)	1,885,027		1,885,027			17
18	Directors Fees											18
19	Professional Services			176,223	176,223	(1,213)	175,010		175,010			19
20	Dues, Fees, Subscriptions & Promotions			43,526	43,526		43,526	(750)	42,776			20
21	Clerical & General Office Expenses	83,635	21,767	195,305	300,707	33,519	334,226	(82,073)	252,153			21
22	Employee Benefits & Payroll Taxes			2,475,151	2,475,151		2,475,151		2,475,151			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,623	9,623		9,623		9,623			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			157,472	157,472		157,472		157,472			26
27	Other (specify):*											27
28	**TOTAL General Administration**	211,491	23,154	4,845,390	5,080,035		5,080,035	(82,823)	4,997,212			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	9,561,069	558,030	7,259,829	17,378,928		17,378,928	(131,643)	17,247,285			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: 4/1/2015 Ending: 3/31/2016

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			1,069,148	1,069,148		1,069,148		1,069,148			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):* Settlement on pension liability			976,763	976,763		976,763	(976,763)				36
37	**TOTAL Ownership**			2,045,911	2,045,911		2,045,911	(976,763)	1,069,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	637,805	1,741,864	866,983	3,246,652		3,246,652		3,246,652			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			388,957	388,957		388,957		388,957			42
43	Other (specify):* AL/IL/Marketing	6,260,685	368,302	15,779,739	22,408,726		22,408,726	(22,408,726)				43
44	**TOTAL Special Cost Centers**	6,898,490	2,110,166	17,035,679	26,044,335		26,044,335	(22,408,726)	3,635,609			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	16,459,559	2,668,196	26,341,419	45,469,174		45,469,174	(23,517,132)	21,952,042			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: 4/1/2015 Ending: 3/31/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(22,645)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(53,564)	21		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	(28,509)	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**	(23,412,414)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,517,132)		$	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))**	$ (23,517,132)		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

STATE OF ILLINOIS

Westminster Place

ID# 0012930

Report Period Beginning: 4/1/2015

Ending: 3/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL Salaries	$ (2,634,626)	43	1
2	IL Salaries	(3,626,059)	43	2
3	AL Supplies	(116,743)	43	3
4	IL Supplies	(251,548)	43	4
5	Marketing Supplies	(11)	43	5
6	AL Other	(4,383,993)	43	6
7	IL Other	(11,323,934)	43	7
8	Marketing Other	(71,812)	43	8
9	Resident Catering	(6,076)	2	9
10	Housekeeping	(570)	3	10
11	Bus Rental	(4,530)	14	11
12	Event Revenue	(7,225)	11	12
13	Craft Sales	(4,999)	11	13
14	Fitness Center Revenue	(2,775)	11	14
15	Settlement on Pension Liability	(976,763)	36	15
16	Evanston Chamber of Commerce dues	(750)	20	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**	(23,412,414)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	(28,721)	0	0	0	0	0	0	0	0	0	0	(28,721)	2
3	Housekeeping	(570)	0	0	0	0	0	0	0	0	0	0	(570)	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**	(29,291)	0	0	0	0	0	0	0	0	0	0	(29,291)	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	(14,999)	0	0	0	0	0	0	0	0	0	0	(14,999)	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	(4,530)	0	0	0	0	0	0	0	0	0	0	(4,530)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,529)	0	0	0	0	0	0	0	0	0	0	(19,529)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(750)	0	0	0	0	0	0	0	0	0	0	(750)	20
21	Clerical & General Office Expenses	(82,073)	0	0	0	0	0	0	0	0	0	0	(82,073)	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**	(82,823)	0	0	0	0	0	0	0	0	0	0	(82,823)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(131,643)	0	0	0	0	0	0	0	0	0	0	(131,643)	29

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):*	(976,763)	0	0	0	0	0	0	0	0	0	0	(976,763)	36
37	**TOTAL Ownership**	(976,763)	0	0	0	0	0	0	0	0	0	0	(976,763)	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):*	(22,408,726)	0	0	0	0	0	0	0	0	0	0	(22,408,726)	43
44	**TOTAL Special Cost Centers**	(22,408,726)	0	0	0	0	0	0	0	0	0	0	(22,408,726)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,517,132)	0	0	0	0	0	0	0	0	0	0	(23,517,132)	45

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	Presbyterian Homes M	Evanston	Management
		James C. King Home	Evanston	Presbyterian Homes O	Evanston	Outpatient Therapy
		Moorings Health Center	Arlington Heights	Ten Twenty Grove, LL	Evanston	Senior Independent

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Management Fee	$ 1,788,090	Presbyterian Homes Manager	0.00%	$ 1,788,090	$	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			$ 1,788,090			$ 1,788,090	$ *	14

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 4/1/2015 Ending: 3/31/2016

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: 4/1/2015 Ending: 3/31/2016

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: 4/1/2015 Ending: 3/31/2016

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		**8**
	2012		**9**
	2013		**10**
	2014		**11**
	2015		**12**

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	**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.**

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 125,319 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			$ 8,252	1
2					2
3	TOTALS			$ 8,252	3

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

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	2010 Fixed Assets			2010	9,175						32
33	2011 Fixed Assets			2011	275,022						33
34	2012 Fixed Assets			2012	293,984						34
35	GREENLEAF CABINETS, INC.			2013	36,960						35
36	OTIS KOGLIN WILSON ARCHITECTS INC			2013	42,800						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: 4/1/2015 Ending: 3/31/2016

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	POWER CONSTRUCTION	2013	$ 381,553	$		$	$	$	37
38	POWER CONSTRUCTION	2013	518,180						38
39	POWER CONSTRUCTION	2013	408,317						39
40	POWER CONSTRUCTION	2013	346,748						40
41	POWER CONSTRUCTION	2013	26,201						41
42	POWER CONSTRUCTION	2013	464,000						42
43	POWER CONSTRUCTION	2013	130,000						43
44	INTERIOR DESIGN ASSOCIATES INC	2013	2,500						44
45	GREENLEAF CABINETS, INC.	2013	30,610						45
46	GREENLEAF CABINETS, INC.	2013	20,160						46
47	GREENLEAF CABINETS, INC.	2013	53,760						47
48	INTERIOR DESIGN ASSOCIATES INC	2013	2,629						48
49	INTERIOR DESIGN ASSOCIATES INC	2013	3,194						49
50	INTERIOR DESIGN ASSOCIATES INC	2013	2,629						50
51	INTERIOR DESIGN ASSOCIATES INC	2013	3,459						51
52	INTERIOR DESIGN ASSOCIATES INC	2013	57,326						52
53	LAKOTA GROUP	2013	6,830						53
54	Power Construction Company	2013	495,893						54
55	ERIKSSON ENGINEERING ASSOC LTD.	2013	1,240						55
56	INTERIOR DESIGN ASSOCIATES INC	2013	3,630						56
57	OKW Architects, Inc.	2013	6,405						57
58	Power Construction Company	2013	678,275						58
59	ERIKSSON ENGINEERING ASSOC LTD.	2013	499						59
60	LAKOTA GROUP	2013	1,893						60
61	INTERIOR DESIGN ASSOCIATES INC	2013	4,443						61
62	Otis,Koglin, Wilson 32226	2013	41,200						62
63	Otis,Koglin, Wilson 32229	2013	67,660						63
64	Otis,Koglin, Wilson 32228	2013	5,940						64
65	Interior Design Assoc 23605	2013	65,045						65
66	LAKOTA GROUP	2013	4,996						66
67	F E MORAN INC	2013	17,475						67
68	PINNACLE SERVICES INC	2013	3,967						68
69	Eriksson Engineering Assoc	2013	753						69
70	TOTAL (lines 4 thru 69)		$ 23,412,775	$		$	$	$	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: 4/1/2015 Ending: 3/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 23,412,775	$		$	$	$	1
2	Power Construction Company	2013	109,273						2
3	THE STATE FIRE MARSHALL	2013	30						3
4	OKW ARCHITECTS INC	2013	1,416						4
5	ATOMATIC MECHANICAL	2014	23,547						5
6	2014 Various	2014	80,300						6
7	McGaw- Mold Remediation	2015	61,764						7
8	McGaw- Mold Remediation	2015	271,860						8
9	WM Contingency Roam Alert McGaw	2015	13,825						9
10	WM Contingency Roam Alert McGaw	2015	14,076						10
11	Foster 1 - 3 FL Common Area Improvements	2016	659,237						11
12	Foster Remediation Work	2016	481,925						12
13	McGaw 1st Floor Improvements	2016	354,841						13
14	Foster Pavilion Improvements	2016	141,616						14
15									15
16	Financial Statement Depreciation			854,147		854,147		14,136,420	16
17	Adjustments to Financials			1,205,819			(1,205,819)	(1,205,819)	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)		$ 25,626,485	$ 2,059,966		$ 854,147	$ (1,205,819)	$ 12,930,601	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: 4/1/2015 Ending: 3/31/2016

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	$ 4,464,256	$	$	$		$ 4,198,842	71
72	Current Year Purchases	719,840						72
73	Fully Depreciated Assets	(1,723,744)						73
74	Financial Statement Depreciation		215,001	215,001			(1,834,589)	74
75	TOTALS	$ 3,460,352	$ 215,001	$ 215,001	$		$ 2,364,253	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)	$ 29,095,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,274,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,069,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,205,819)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,294,854	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	$ 25,996,326	$ 908,090	$ 17,036,555	86
87	IL	111,613,308	4,695,845	59,315,605	87
88					88
89					89
90					90
91	TOTALS	$ 137,609,634	$ 5,603,935	$ 76,352,160	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 4/1/2015 Ending: 3/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service		3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	1710	hrs	$ 81,189	16	$ 1,479	$	1,726	$ 82,668	1
2	Licensed Speech and Language Development Therapist	39-1	285	hrs	10,634	17	1,156		302	11,790	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39-1	2559	hrs	120,515	137	7,519	21,820	2,696	149,854	4
5	Physician Care		542	visits	56,597			211,236	542	267,833	5
6	Dental Care			visits				125,783		125,783	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy		37800	# of prescrpts	291,009		15,090	1,383,025	37,800	1,689,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Director of Rehab/Ther	39-3	1159		77,861				1,159	77,861	12
13	Other (specify): Management Fees	39-3					841,739			841,739	13
14	TOTAL				$ 637,805	170	$ 866,983	$ 1,741,864	44,225	$ 3,246,652	14

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2015 Ending: 3/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 3/31/2016 (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	$ 853,405	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (210,000))	1,568,726		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,212,218		5
6	Prepaid Insurance	176,732		6
7	Other Prepaid Expenses	260,517		7
8	Accounts Receivable (owners or related parties)	(403,861)		8
9	Other(specify): See attached schedule	255,489		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,923,226	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,951,043		12
13	Land	5,622,814		13
14	Buildings, at Historical Cost	144,005,488		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,076,423		16
17	Accumulated Depreciation (book methods)	(91,647,013)		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	3,824,339		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 89,833,094	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 93,756,320	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,772,535	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			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	14,011		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,043,840		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,830,386	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,000,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	71,919,709		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 85,919,709	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 92,750,095	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,006,225	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 93,756,320	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 34,314,489	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 34,314,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	953,152	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) Re-organization items	(34,261,416)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (33,308,264)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,006,225	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 37,910,253	1
2	Discounts and Allowances for all Levels	(4,878,258)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 33,031,995	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,418,394	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,418,394	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	70,909	12
13	Barber and Beauty Care	228,206	13
14	Non-Patient Meals	202,792	14
15	Telephone, Television and Radio	17,426	15
16	Rental of Facility Space	213,332	16
17	Sale of Drugs	1,498,045	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	395,968	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,626,678	23
	D. Non-Operating Revenue		
24	Contributions	3,263,868	24
25	Interest and Other Investment Income***	322,959	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,586,827	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous	4,758,432	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,758,432	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 46,422,326	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,918,564	31
32	Health Care	8,380,329	32
33	General Administration	5,080,035	33
	B. Capital Expense		
34	Ownership	2,045,911	34
	C. Ancillary Expense		
35	Special Cost Centers	25,655,378	35
36	Provider Participation Fee	388,957	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 45,469,174	40
41	**Income before Income Taxes (line 30 minus line 40)****	953,152	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 953,152	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 158,350	44
45	Private Pay - Net Inpatient Revenue	29,980,864	45
46	Medicare - Net Inpatient Revenue	2,844,025	46
47	Other-(specify) Insurance	48,756	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 33,031,995	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,680	1,961	$ 107,131	$ 54.63	1
2	Assistant Director of Nursing	1,913	2,188	107,040	48.92	2
3	Registered Nurses	73,726	81,848	3,125,340	38.18	3
4	Licensed Practical Nurses	8,493	9,291	272,665	29.35	4
5	CNAs & Orderlies	156,159	172,563	2,663,911	15.44	5
6	CNA Trainees					6
7	Licensed Therapist	4,077	4,560	212,338	46.57	7
8	Rehab/Therapy Aides	418	484	7,342	15.17	8
9	Activity Director					9
10	Activity Assistants	12,388	13,463	252,776	18.78	10
11	Social Service Workers	3,881	4,853	166,885	34.39	11
12	Dietician					12
13	Food Service Supervisor	1,286	1,364	36,898	27.05	13
14	Head Cook	7,615	8,586	137,493	16.01	14
15	Cook Helpers/Assistants	36,757	39,837	520,518	13.07	15
16	Dishwashers	6,766	7,413	84,766	11.43	16
17	Maintenance Workers	4,291	4,732	106,880	22.59	17
18	Housekeepers	25,314	28,140	316,489	11.25	18
19	Laundry	6,710	7,279	86,371	11.87	19
20	Administrator	2,184	2,604	228,371	87.70	20
21	Assistant Administrator					21
22	Other Administrative	707	911	31,704	34.80	22
23	Office Manager	10,251	11,444	452,362	39.53	23
24	Clerical	14,337	16,222	352,669	21.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	534	567	74,304	131.05	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,129	1,258	25,656	20.39	31
32	Other Health C: AL/IL/Marketing	287,146	314,783	6,260,685	19.89	32
33	Other(specify) Other	27,916	30,513	828,965	27.17	33
34	TOTAL (lines 1 - 33)	695,678	766,864	$ 16,459,559 *	$ 21.46	34

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

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 559	10-3	50
51	Licensed Practical Nurses	8	352	10-3	51
52	Certified Nurse Assistants/Aides	478	11,136	10-3	52
53	TOTAL (lines 50 - 52)	494	$ 12,047		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Stohlgren	Executive Director		$ 95,550
($127856 col 1 minus $32,306 col 5)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,550

B. Administrative - Other

Description	Amount
Management Fee	$ 1,788,090
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,788,090

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule		$ 176,223
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 176,223

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,243
Unemployment Compensation Insurance	10,963
FICA Taxes	751,661
Employee Health Insurance	1,104,396
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,349
Retirement	444,270
Disability	21,269
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,475,151

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	24,275
Licenses and Fees	19,251
Less: Public Relations Expense	(750)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,776

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,122
Seminar Expense	8,501
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,623

**See instructions.

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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. **No**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **388,957**
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. $ **22,645**

(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? **No**
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 out of Schedule V? **Yes**

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