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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 4/1/2016 to 3/31/2017 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

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: 4/1/2016 Ending: 3/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	720	22,369	8,126	31,215	8
9	SNF/PED					9
10	ICF		25,781		25,781	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	720	48,150	8,126	56,996	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.24%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [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 8,126

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: 3/31/2017 Fiscal Year: 3/31/2017

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	805,300	746	1,407,995	2,214,041		2,214,041	(25,252)	2,188,789			1
2	Food Purchase		6,249		6,249		6,249	(3,405)	2,844			2
3	Housekeeping	347,548	28,876	78,728	455,152		455,152	(15)	455,137			3
4	Laundry	93,424	30,028	8,494	131,946		131,946		131,946			4
5	Heat and Other Utilities			253,975	253,975		253,975		253,975			5
6	Maintenance	270,284	40,139	401,036	711,459	52,784	764,243	(6,202)	758,041			6
7	Other (specify):*											7
8	TOTAL General Services	1,516,556	106,038	2,150,228	3,772,822	52,784	3,825,606	(34,874)	3,790,732			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	7,557,194	414,339	455,851	8,427,384	(168,509)	8,258,875	(22,868)	8,236,007			10
10a	Therapy		15,036	1,174,381	1,189,417		1,189,417		1,189,417			10a
11	Activities	259,022	11,617	45,356	315,995	17,171	333,166	(33,804)	299,362			11
12	Social Services	274,287	1,805	16,652	292,744		292,744	(13,687)	279,057			12
13	CNA Training											13
14	Program Transportation	116,426	1,347	184	117,957		117,957	(1,787)	116,170			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,206,929	444,144	1,692,424	10,343,497	(151,338)	10,192,159	(72,146)	10,120,013			16
	C. General Administration											
17	Administrative	137,362	188	1,561,630	1,699,180	137,344	1,836,524	(270,347)	1,566,177			17
18	Directors Fees											18
19	Professional Services			261,505	261,505	(24,599)	236,906		236,906			19
20	Dues, Fees, Subscriptions & Promotions			94,758	94,758	(52,784)	41,974		41,974			20
21	Clerical & General Office Expenses	269,647	71,272	293,791	634,710	32,778	667,488	(381,724)	285,764			21
22	Employee Benefits & Payroll Taxes			2,572,471	2,572,471	23,624	2,596,095		2,596,095			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,336	9,336	(638)	8,698		8,698			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			167,442	167,442		167,442		167,442			26
27	Other (specify):*											27
28	TOTAL General Administration	407,009	71,460	4,960,933	5,439,402	115,725	5,555,127	(652,071)	4,903,056			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,130,494	621,642	8,803,585	19,555,721	17,171	19,572,892	(759,091)	18,813,801			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: 4/1/2016 Ending: 3/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,277,325	1,277,325	(307,113)	970,212		970,212			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**			1,277,325	1,277,325	(307,113)	970,212		970,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	333,458	691,759	13,975	1,039,192		1,039,192		1,039,192			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			405,175	405,175		405,175		405,175			42
43	Other (specify):* AL/IL Marketing	6,678,232	488,157	16,700,558	23,866,947	289,942	24,156,889	(24,156,889)				43
44	**TOTAL Special Cost Centers**	7,011,690	1,179,916	17,119,708	25,311,314	289,942	25,601,256	(24,156,889)	1,444,367			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	17,142,184	1,801,558	27,200,618	46,144,360		46,144,360	(24,915,980)	21,228,380			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: 4/1/2016 Ending: 3/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(25,252)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(90,439)	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	(94,619)	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	(24,435,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,645,633)		$	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)	(270,347)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (270,347)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,915,980)		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: 4/1/2016

Ending: 3/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL Salaries	$ (2,941,113)	43	1
2	IL Salaries	(3,719,948)	43	2
3	AL Supplies	(147,107)	43	3
4	IL Supplies	(341,050)	43	4
5	AL Other	(4,498,198)	43	5
6	IL Other	(12,119,548)	43	6
7	Marketing Other	(82,812)	43	7
8	Resident Catering	(3,405)	2	8
9	Housekeeping	(15)	3	9
10	Bus Rental	(1,787)	14	10
11	Event Revenue	(8,304)	11	11
12	Craft Sales	(4,054)	11	12
13	Al/IL depreciation	(307,113)	43	13
14	Grants from Geneva Foundation	(6,202)	6	14
15	Grants from Geneva Foundation	(22,868)	10	15
16	Grants from Geneva Foundation	(21,446)	11	16
17	Grants from Geneva Foundation	(13,687)	12	17
18	Grants from Geneva Foundation	(196,666)	21	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**	(24,435,323)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(25,252)	0	0	0	0	0	0	0	0	0	0	(25,252)	1
2	Food Purchase	(3,405)	0	0	0	0	0	0	0	0	0	0	(3,405)	2
3	Housekeeping	(15)	0	0	0	0	0	0	0	0	0	0	(15)	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	(6,202)	0	0	0	0	0	0	0	0	0	0	(6,202)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(34,874)	0	0	0	0	0	0	0	0	0	0	(34,874)	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	(22,868)	0	0	0	0	0	0	0	0	0	0	(22,868)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(33,804)	0	0	0	0	0	0	0	0	0	0	(33,804)	11
12	Social Services	(13,687)	0	0	0	0	0	0	0	0	0	0	(13,687)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,787)	0	0	0	0	0	0	0	0	0	0	(1,787)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(72,146)	0	0	0	0	0	0	0	0	0	0	(72,146)	16
	C. General Administration													
17	Administrative	(270,347)	0	0	0	0	0	0	0	0	0	0	(270,347)	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	(381,724)	0	0	0	0	0	0	0	0	0	0	(381,724)	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	(652,071)	0	0	0	0	0	0	0	0	0	0	(652,071)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(759,091)	0	0	0	0	0	0	0	0	0	0	(759,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westminster Place # 0012930 **Report Period Beginning:** 4/1/2016 **Ending:** 3/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	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):*	(24,156,889)	0	0	0	0	0	0	0	0	0	0	(24,156,889)	43
44	**TOTAL Special Cost Centers**	(24,156,889)	0	0	0	0	0	0	0	0	0	0	(24,156,889)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,915,980)	0	0	0	0	0	0	0	0	0	0	(24,915,980)	45

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Presbyterian Homes	100	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	17	Management Fee	$ 1,561,630	Presbyterian Homes Manager	0.00%	$ 1,291,283	$ (270,347)	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			$ 1,561,630			$ 1,291,283	$ * (270,347)	14

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEE HUTCHINSON	CHAIR							$		1
2	PAULA NOBLE	SECRETARY									2
3	MARSHALL PECK	TREASURER									3
4	CHARLES DENISON	DIRECTOR									4
5	GEORGE DROST	DIRECTOR									5
6	GREG HUMMEL	DIRECTOR									6
7	DENNIS MARX	DIRECTOR									7
8	BETSY NICHOLS	DIRECTOR									8
9	MONICA HEENAN	DIRECTOR									9
10	HARLAN STANLEY	DIRECTOR									10
11	MARK TOLEDO	DIRECTOR									11
12	See PG7A for remaining										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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other ırsing Home	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		
12	JANE WESTERN	DIRECTOR							$		1
13	DENNIS MURPHY	DIRECTOR									2
14	MICHAEL KIRBY	DIRECTOR									3
15	MARK DENNIS	DIRECTOR									4
16	FRAN CARROLL	DIRECTOR									5
											6
											7
											8
											9
											10
											11
											12

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	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: 4/1/2016 Ending: 3/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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).

Independent Living facility in Westminster Place contains 144 apartments and 108 townhouses/cottages. Total square forage is 517,872.

Assisted Living facility in Westminster Place contains 92 apartments. Total square footage is 124,346.

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/2016 Ending: 3/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	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: 4/1/2016 Ending: 3/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	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)		$ 23,412,774	$		$	$	$	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: 4/1/2016 Ending: 3/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 23,412,774	$		$	$	$	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 - Model Remediation	2015	61,764						7
8	McGaw - Model 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 - Demolition, rough	2016	659,237						11
12	Foster Remediation Work - removing mold behind the wall	2016	481,925						12
13	McGaw 1st Floor Improvements - Demolition, rough carpenty, mi	2016	354,841						13
14	Foster Pavilion Improvements - Demolition, rough carpenty, millw	2016	141,616						14
15	Foster Lower Level Improvements - Flooring	2017	29,140		5				15
16	Foster Lower Level Improvements - Electrical, flooring, HVAC, p	2017	261,309		10				16
17	Foster room renovation - The Inn - Flooring, Counter top with und	2017	301,484		10				17
18	Foster room renovation - The Inn - Flooring, Counter top with und	2017	238,355		10				18
19	Pharmacy renovation - Interior designing, electrical drawing and	2017	12,719		10				19
20	Roof - McGaw	2017	502,354		20				20
21									21
22	Financial Statement Depreciation			772,759		772,759		13,703,360	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)		$ 26,971,845	$ 772,759		$ 772,759	$	$ 13,703,360	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: 4/1/2016 Ending: 3/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,460,354	$	$	$		$ 2,364,253	71
72	Current Year Purchases	259,800						72
73	Fully Depreciated Assets							73
74	Financial Statement Depreciation		197,453	197,453			197,453	74
75	TOTALS	$ 3,720,154	$ 197,453	$ 197,453	$		$ 2,561,706	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)	$ 30,700,251	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 970,212	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 970,212	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)	$ 16,265,066	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	$ 28,863,623	$ 1,180,753	$ 18,052,520	86
87	IL	118,305,273	5,145,304	64,621,706	87
88					88
89					89
90					90
91	TOTALS	$ 147,168,896	$ 6,326,057	$ 82,674,226	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 26,425	92
93			93
94			94
95		$ 26,425	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: 4/1/2016 Ending: 3/31/2017

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 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: 4/1/2016 Ending: 3/31/2017

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Westminster Place | STATE OF ILLINOIS # 0012930 | Report Period Beginning: 4/1/2016 Ending: 3/31/2017

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	10a-2, 10a-3	hrs	$	24,719	$ 450,371	$ 5,766	24,719	$ 456,137	1
2	Licensed Speech and Language Development Therapist	10a-2, 10a-3	hrs		2,816	121,249	1,553	2,816	122,802	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-2, 10a-3	hrs		35,607	602,761	7,717	35,607	610,478	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-1, 39-2	37398 # of prescrpts	333,458			691,759	37,398	1,025,217	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 333,458	63,142	$ 1,174,381	$ 706,795	100,540	$ 2,214,634	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:** 4/1/2016 **Ending:** 3/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 3/31/2017 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,496,536	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (310,000))	2,369,163		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,707		6
7	Other Prepaid Expenses	131,571		7
8	Accounts Receivable (owners or related parties)	(928,488)		8
9	Other(specify): See attached schedule	301,439		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,524,928	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,146,426		12
13	Land	5,675,896		13
14	Buildings, at Historical Cost	153,134,534		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,058,717		16
17	Accumulated Depreciation (book methods)	(98,939,292)		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	987,028		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 93,063,309	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 96,588,237	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,744,752	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	448,101		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	171,853		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,800,136		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,164,842	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	13,205,105		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached			43
44		71,462,294		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 84,667,399	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 92,832,241	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,755,996	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 96,588,237	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,006,228	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,006,228	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,925,270	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) Change in Minimum Pension Liability	(175,502)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,749,768	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,755,996	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	$ 40,339,424	1
2	Discounts and Allowances for all Levels	(4,262,733)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 36,076,691	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,752,808	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,752,808	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	66,011	12
13	Barber and Beauty Care	217,434	13
14	Non-Patient Meals	197,573	14
15	Telephone, Television and Radio	42,736	15
16	Rental of Facility Space	312,967	16
17	Sale of Drugs	1,178,164	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	163,201	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,178,086	23
	D. Non-Operating Revenue		
24	Contributions	2,705,946	24
25	Interest and Other Investment Income***	324,217	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,030,163	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	5,031,882	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,031,882	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 49,069,630	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,772,822	31
32	Health Care	10,343,497	32
33	General Administration	5,439,402	33
	B. Capital Expense		
34	Ownership	1,277,325	34
	C. Ancillary Expense		
35	Special Cost Centers	24,906,139	35
36	Provider Participation Fee	405,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 46,144,360	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,925,270	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,925,270	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 126,867	44
45	Private Pay - Net Inpatient Revenue	33,168,323	45
46	Medicare - Net Inpatient Revenue	2,843,511	46
47	Other-(specify) Insurance	(62,010)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 36,076,691	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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,736	1,954	$ 124,781	$ 63.86	1
2	Assistant Director of Nursing	2,125	2,392	127,453	53.28	2
3	Registered Nurses	75,983	83,461	3,338,245	40.00	3
4	Licensed Practical Nurses	7,118	7,818	245,730	31.43	4
5	CNAs & Orderlies	155,868	170,724	2,804,712	16.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	547	650	19,889	30.60	9
10	Activity Assistants	12,450	13,680	266,741	19.50	10
11	Social Service Workers	4,392	4,959	187,747	37.86	11
12	Dietician	770	807	12,929	16.02	12
13	Food Service Supervisor	1,351	1,430	38,728	27.08	13
14	Head Cook	10,292	11,431	212,554	18.59	14
15	Cook Helpers/Assistants	36,341	38,754	478,780	12.35	15
16	Dishwashers	5,669	6,176	76,055	12.31	16
17	Maintenance Workers	4,433	4,940	102,623	20.77	17
18	Housekeepers	25,077	27,568	331,495	12.02	18
19	Laundry	6,707	7,185	97,603	13.58	19
20	Administrator	1,733	1,954	169,147	86.56	20
21	Assistant Administrator					21
22	Other Administrative	31,652	34,734	1,192,088	34.32	22
23	Office Manager	4,757	5,239	202,983	38.74	23
24	Clerical	7,881	8,614	148,224	17.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	422	433	58,150	134.30	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,915	2,132	42,832	20.09	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	262	337	12,080	35.85	31
32	Other Health C: Other	4,827	5,301	189,554	35.76	32
33	Other(specify) AL/IL/Marketing	295,183	322,628	6,661,061	20.65	33
34	TOTAL (lines 1 - 33)	699,491	765,301	$ 17,142,184 *	$ 22.40	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				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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	188	$ 12,110	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,122	72,886	10-3	52
53	TOTAL (lines 50 - 52)	3,309	$ 84,996		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Stohlgren	VP Executive Director		$ 105,559
Linda Dotson	Health Care Administrator		169,147
(Col 1 + Col 5 Reclass)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 274,706

B. Administrative - Other

Description	Amount
Management Fee	$ 1,561,630
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,561,630
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule		$ 236,906
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 236,906

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 190,284
Unemployment Compensation Insurance	24,420
FICA Taxes	750,736
Employee Health Insurance	1,174,376
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,939
Long-Term Disability Insurance	17,930
Retirement	412,786
Pension Plan	23,624
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,596,095

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Memberships & Publications	22,204
Licenses and Fees	17,780
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,974

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	223
Seminar Expense	8,475
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,698

**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? **Yes** If YES, what is the capacity? **195**

(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? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **405,175**
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? **Yes** 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. $ **25,252**

(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 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

Position	First Name	Last Name	Total Salary	Accrual	AIP	Salary Expenses	Allocated to H/C	Remaining to IL/AL
Executive Director	**Keith**	Stohlgren	$ 243,074.00	$ 35,569.00	$ 29,439.00	$ 308,082.00	$ 105,559	$ 202,523
							34.30%	65.70%
Director, Activities	**Nancy**	Ichinose	$ 51,517.00	$ 8,059.00	$ -	$ 59,576.00	$ 19,889	$ 39,687
							33.40%	66.60%
Grand Total			**$ 294,591.00**	**$ 43,628.00**	**$ 29,439.00**	**$ 367,658.00**	**$ 125,448.00**	**$ 242,210.00**