FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 847-866-1650 **Fax #** 847-570-3399

HFS ID Number:

Date of Initial License for Current Owners: 2/20/1967

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: Joshua S. Banach **Telephone Number:** (847) 628-8784
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 4/1/19 to 3/31/20 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) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Denise A. Leonard, CPA, Partner
(Firm Name & Address) Plante Moran, PLLC, 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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: 4/1/19 Ending: 3/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,430	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 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	2,726	14,769	8,815	26,310	8
9	SNF/PED					9
10	ICF		31,185		31,185	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,726	45,954	8,815	57,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.60%

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 10/1/1922

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 105 and days of care provided 7,312

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: 3/31/2020 Fiscal Year: 3/31/2020

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	727,508	87,522	432,927	1,247,957		1,247,957		1,247,957			1
2	Food Purchase		675,327		675,327		675,327		675,327			2
3	Housekeeping	355,130	58,660	24,976	438,766		438,766		438,766			3
4	Laundry	112,497	36,480	6,551	155,528		155,528		155,528			4
5	Heat and Other Utilities			229,363	229,363		229,363		229,363			5
6	Maintenance	223,994	234,968	119,106	578,068		578,068		578,068			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,419,129	1,092,957	812,923	3,325,009		3,325,009		3,325,009			8
	B. Health Care and Programs											
9	Medical Director	23,828			23,828		23,828		23,828			9
10	Nursing and Medical Records	7,415,350	494,463	718,184	8,627,997		8,627,997		8,627,997			10
10a	Therapy		11,663	1,338,267	1,349,930		1,349,930		1,349,930			10a
11	Activities	287,880	12,616	14,989	315,485		315,485		315,485			11
12	Social Services	236,714			236,714		236,714		236,714			12
13	CNA Training											13
14	Program Transportation	142,873		1,520	144,393		144,393		144,393			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	8,106,645	518,742	2,072,960	10,698,347		10,698,347		10,698,347			16
	C. General Administration											
17	Administrative	189,082		1,817,016	2,006,098		2,006,098	(543,188)	1,462,910			17
18	Directors Fees											18
19	Professional Services			224,362	224,362		224,362	(232)	224,130			19
20	Dues, Fees, Subscriptions & Promotions			54,164	54,164		54,164		54,164			20
21	Clerical & General Office Expenses	661,465	45,166	467,864	1,174,495		1,174,495	(295,372)	879,123			21
22	Employee Benefits & Payroll Taxes			2,830,449	2,830,449		2,830,449		2,830,449			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,947	4,947		4,947		4,947			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			289,937	289,937		289,937		289,937			26
27	Other (specify):* Marketing/Advert			28,857	28,857		28,857	(28,857)				27
28	**TOTAL General Administration**	850,547	45,166	5,717,596	6,613,309		6,613,309	(867,649)	5,745,660			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	10,376,321	1,656,865	8,603,479	20,636,665		20,636,665	(867,649)	19,769,016			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: 4/1/19 Ending: 3/31/20

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			1,661,372	1,661,372		1,661,372	(509,455)	1,151,917			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			26,198	26,198		26,198		26,198			35
36	Other (specify):* HO Capital							88,214	88,214			36
37	**TOTAL Ownership**			1,687,570	1,687,570		1,687,570	(421,241)	1,266,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			410,531	410,531		410,531		410,531			42
43	Other (specify):* Clinic	352,854	15,526	44,460	412,840		412,840	(412,840)				43
44	**TOTAL Special Cost Centers**	352,854	15,526	454,991	823,371		823,371	(412,840)	410,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,729,175	1,672,391	10,746,040	23,147,606		23,147,606	(1,701,730)	21,445,876			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: 4/1/19 Ending: 3/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(509,455)	30		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	(7,414)	21		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	(284,439)	21		24
25	Fund Raising, Advertising and Promotional	(28,857)	27		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	(435,662)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,265,827)		$	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)	(435,903)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (435,903)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,701,730)		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: 4/1/19

Ending: 3/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-SNF Related Lease Revenue	$ (19,071)	36	1
2	Community Engagement	(3,519)	21	2
3	Clinic Services	(412,840)	43	3
4	Collections Expense	(232)	19	4
5				5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(435,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	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**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(543,188)	0	0	0	0	0	0	0	0	0	(543,188)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(232)	0	0	0	0	0	0	0	0	0	0	(232)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(295,372)	0	0	0	0	0	0	0	0	0	0	(295,372)	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):*	(28,857)	0	0	0	0	0	0	0	0	0	0	(28,857)	27
28	**TOTAL General Administration**	(324,461)	(543,188)	0	0	0	0	0	0	0	0	0	(867,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(324,461)	(543,188)	0	0	0	0	0	0	0	0	0	(867,649)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westminster Place **#** 0012930 **Report Period Beginning:** 4/1/19 **Ending:** 3/31/20

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(509,455)	0	0	0	0	0	0	0	0	0	0	(509,455)	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):*	(19,071)	107,285	0	0	0	0	0	0	0	0	0	88,214	36
37	**TOTAL Ownership**	(528,526)	107,285	0	0	0	0	0	0	0	0	0	(421,241)	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):*	(412,840)	0	0	0	0	0	0	0	0	0	0	(412,840)	43
44	**TOTAL Special Cost Centers**	(412,840)	0	0	0	0	0	0	0	0	0	0	(412,840)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,265,827)	(435,903)	0	0	0	0	0	0	0	0	0	(1,701,730)	45

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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 Place)	Lake Forest, IL	Presbyterian Homes Manager	Evanston	Management
		The Moorings Health Center	Arlington Heights, IL	Presbyterian Homes Outpatient Rehab Agency, LLC	Evanston	Outpatient Therapy
				Ten Twenty Grove, LLC	Evanston	Senior Ind. Living

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office A&G	$ 1,817,016	Presbyterian Homes Manager	0.00%	$ 1,273,828	$ (543,188)	1
2	V	36	Home Office Capital		Presbyterian Homes Manager	0.00%	107,285	107,285	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			$ 1,817,016			$ 1,381,113	$ * (435,903)	14

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	Board of Directors								$		1
2	Paula Noble	Board Chair									2
3	Michael Kirby	Secretary									3
4	Neele Stearns	Treasurer									4
5	Terri Brady	Director									5
6	Charlie Denison	Director									6
7	David Donnersberger	Director									7
8	Monica Heenan	Director									8
9	Elinor Hite	Director									9
10	Lee Hutchinson	Director									10
11	Vince Kelly	Director									11
12	See Supplemental Page 7										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: 4/1/19 Ending: 3/31/20

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Thomas McAfee	Director							$		1
2	Dennis Marx	Director									2
3	Marshall Peck	Director									3
4	Mark Toledo	Director									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: 4/1/19 Ending: 3/31/20

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: 4/1/19 Ending: 3/31/20

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 ☐

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: 4/1/19 Ending: 3/31/20

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 ☐

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: 4/1/19 Ending: 3/31/20

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 ☐

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: 4/1/19 Ending: 3/31/20

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 ☐

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: 4/1/19 Ending: 3/31/20

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							$	$			$	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	Presbyterian Homes Manager	X		To Terminate Defined		2/8/2018	3,040,000		2/1/2020	3.4370	7,204	10
11	Offset By Interest Income			Benefit Plan							(7,204)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 3,040,000	$			$	14
15	TOTALS (line 9+line14)						$ 3,040,000	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** 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: 4/1/19 Ending: 3/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

Facility did not pay real estate taxes due to non-profit status

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westminster Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012930

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 4/1/19 Ending: 3/31/20

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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Independent Living facility in Westminster Place contains 144 apartments and 101 townhouses/cottages. Total square footage is 517,872.

Assisted Living facility in Westminster Place contains 93 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: 4/1/19 Ending: 3/31/20

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: 4/1/19 Ending: 3/31/20

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: 4/1/19 Ending: 3/31/20

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 ca	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, mill	2016	354,841						13
14	Foster Pavilion Improvements - Demolition, rough carpenty, millwo	2016	141,616						14
15	Foster Lower Level Improvements - Flooring	2017	29,140		5				15
16	Foster Lower Level Improvements - Electrical, flooring, HVAC, pai	2017	261,309		10				16
17	Foster room renovation - The Inn - Flooring, Counter top with unde	2017	301,484		10				17
18	Foster room renovation - The Inn - Flooring, Counter top with unde	2017	238,355		10				18
19	Pharmacy renovation - Interior designing, electrical drawing and pi	2017	12,719		10				19
20	Roof - McGaw	2017	502,354		20				20
21	Masonry renovation-tuckpointing	2017	490,309		20				21
22	Masonry renovation-tuckpointing	2018	91,184		20				22
23	Installing cross connection	2017	72,450		20				23
24	Foster room renovation-flooring, counter top with under mount sin	2017	225,367		10				24
25	Foster room renovation-flooring, counter top with under mount sin	2018	60,434		10				25
26	Pharmacy renovation - Interior designing, electrical drawing and pi	2017	122,450		10				26
27	Roof - Foster Pavillion	2017	380,848		20				27
28	Roof - Foster Pavillion	2018	3,500		20				28
29	Rehab bathroom renovation-flooring, counter top with under moun	2017	2,052		10				29
30	New floor for general rehab area and related offices under Foster P	2019	71,000		10				30
31	Electrical-Install dedicated circuits/receptacles in each kitchenette i	2020	9,216		10				31
32									32
33	Financial Statement Depreciation			880,275		880,275		16,311,975	33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

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 12E, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

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 12F, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

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 12G, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

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 12H, Carried Forward		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 28,500,655	$ 880,275		$ 880,275	$	$ 16,311,975	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: 4/1/19 Ending: 3/31/20

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	$ 4,178,020	$	$	$		$ 3,006,995	71
72	Current Year Purchases	147,411						72
73	Fully Depreciated Assets							73
74	Financial Statement Depreciation		271,642	271,642			271,642	74
75	TOTALS	$ 4,325,431	$ 271,642	$ 271,642	$		$ 3,278,637	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)	$ 32,834,338	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,151,917	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,151,917	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)	$ 19,590,612	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living	$ 30,901,119	$ 1,064,438	$ 21,208,506	86
87	Independent Living	143,191,314	6,655,365	83,295,230	87
88					88
89					89
90					90
91	TOTALS	$ 174,092,433	$ 7,719,803	$ 104,503,736	91

G. Construction-in-Progress

	Description	Cost	
92	CIP (Renovation)	$ 1,296,661	92
93			93
94			94
95		$ 1,296,661	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: 4/1/19 Ending: 3/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 26,198 Description: $11,945 Knife Service/Catering/China; $2,619 Fingerprinter; $11,634 Printer/Copier
(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: 4/1/19 Ending: 3/31/20

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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	$	27,740	$ 541,727	$ 4,721	27,740	$ 546,448	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		2,117	101,230	882	2,117	102,112	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		39,649	695,310	6,060	39,649	701,370	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	V39								12
13	Other (specify):	V39								13
14	TOTAL			$	69,506	$ 1,338,267	$ 11,663	69,506	$ 1,349,930	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:** 4/1/19 **Ending:** 3/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 3/31/20 **(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	$ 15,552,532	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 490,048)	2,860,265		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	331,990		6
7	Other Prepaid Expenses	461,538		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,206,325	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	18,918,306		12
13	Land	5,875,916		13
14	Buildings, at Historical Cost	176,284,454		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,766,401		16
17	Accumulated Depreciation (book methods)	(124,094,348)		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	854,743		22
23	Other(specify): See Attached	1,296,661		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 103,902,133	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 123,108,458	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,437,724	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	463,639		29
30	Accrued Salaries Payable	2,787,927		30
31	Accrued Taxes Payable (excluding real estate taxes)	343,883		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	157,020		33
34	Deferred Compensation	48,827		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,077,064		36
37	See Attached	4,997,420		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,313,504	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,446,209		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	75,804,688		43
44	See Attached	4,388,778		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 91,639,675	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 105,953,179	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,155,279	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 123,108,458	$	48

***(See instructions.)**

Westminster Place
0012930
3/31/20
Page 17 Support

PG 17 Line 9 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
Total			-

PG 17 Line 22 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1410.3	40-90-100-12810	Deposit LT	242,543
1430.7	40-20-100-10860	Entrance Fee Receivable	612,200
Total			854,743

PG 17 Line 23 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1200.99	40-90-100-15110	Construction in Progress	1,210,548
1430.7	40-90-010-15000	Fixed Assets Clearing	86,113
Total			1,296,661

PG 17 Line 36 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
2430.00	40-90-100-19610	Due To/From Geneva	498,334
2430.00	40-90-100-19710	Due To/From Corporate	(1,575,398)
Total			(1,077,064)

PG 17 Line 37 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2090.30	40-30-100-20515	Provider Tax Liability	(74,382)
2090.30	40-30-100-22020	Health Care Deposits	(683,244)
2090.30	40-90-100-23545	Women's Board Agency Acct-7717	(52,229)
2090.30	40-90-100-23546	Women's Board Agency Account	(38,725)
2090.30	40-10-100-23510	Deposits & Found Fee Adv	(40,600)
2090.30	40-20-100-23510	Deposits & Found Fee Adv	(573,240)
2090.30	40-20-100-23519	Refundable Entrance Fees	(3,535,000)
Total			(4,997,420)

PG 17 Line 43 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2450.10	40-20-100-23050	Long Term Refundable Entr Fees	(40,841,303)
2450.10	40-20-100-23055	Advance Refund To Resident A/R	641,410
2450.20	40-20-100-23010	Unamortized Entrance Fees	(35,604,795)
Total			(75,804,688)

PG 17 Line 44 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2450.30	40-90-100-20561	Accretion Liability-Asbestos	(4,388,778)
Total			(4,388,778)

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,152,699	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,152,699	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,943,756	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,943,756	17	
	B. Transfers (Itemize):			
18	**ILU & ALU net asset activity for the year**	(941,176)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (941,176)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,155,279	24	*

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

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	$ 26,268,885	1
2	Discounts and Allowances for all Levels	(2,461,058)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 23,807,827	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,494,471	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,494,471	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	19,071	16
17	Sale of Drugs	14,560	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	39,932	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,563	23
	D. Non-Operating Revenue		
24	Contributions	1,471,909	24
25	Interest and Other Investment Income***	45,361	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,517,270	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Clinic Revenue(Adjusted on Page 5A)	198,231	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 198,231	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 28,091,362	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,325,009	31
32	Health Care	10,698,347	32
33	General Administration	6,613,309	33
	B. Capital Expense		
34	Ownership	1,687,570	34
	C. Ancillary Expense		
35	Special Cost Centers	412,840	35
36	Provider Participation Fee	410,531	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 23,147,606	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,943,756	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,943,756	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 420,807	44
45	Private Pay - Net Inpatient Revenue	19,694,812	45
46	Medicare - Net Inpatient Revenue	3,117,793	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	574,415	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 23,807,827	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.**

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	1,718	1,970	$ 143,113	$ 72.65	1
2	Assistant Director of Nursing	3,768	4,184	216,519	51.75	2
3	Registered Nurses	77,982	85,319	3,670,291	43.02	3
4	Licensed Practical Nurses	12,742	13,724	427,545	31.15	4
5	CNAs & Orderlies	148,562	161,367	2,908,731	18.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,761	2,019	55,766	27.62	9
10	Activity Assistants	10,393	12,095	232,114	19.19	10
11	Social Service Workers	5,428	6,215	236,714	38.09	11
12	Dietician					12
13	Food Service Supervisor	4,428	4,907	101,500	20.68	13
14	Head Cook	6,126	6,782	124,420	18.35	14
15	Cook Helpers/Assistants	27,921	30,861	419,178	13.58	15
16	Dishwashers	5,468	6,200	82,410	13.29	16
17	Maintenance Workers	4,058	4,545	112,048	24.65	17
18	Housekeepers	23,643	26,084	355,130	13.61	18
19	Laundry	7,423	8,390	112,497	13.41	19
20	Administrator	1,703	2,030	189,082	93.14	20
21	Assistant Administrator					21
22	Other Administrative	11,631	13,283	490,865	36.95	22
23	Office Manager					23
24	Clerical	7,807	8,618	170,600	19.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	159	178	23,828	133.87	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,384	1,587	49,151	30.97	31
32	Other Health Care: Secur/Trans	13,724	15,414	254,819	16.53	32
33	Other(specify) Clinic	3,734	4,671	352,854	75.54	33
34	TOTAL (lines 1 - 33)	381,563	420,443	$ 10,729,175 *	$ 25.52	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	19	$ 1,305	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,773	187,969	10-3	52
53	TOTAL (lines 50 - 52)	6,792	$ 189,274		53

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bill Casper	HC Administrator	0.00%	$ 189,082
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 189,082

B. Administrative - Other

Description	Amount
Management Fee- Presbyterian Home Manager	$ 1,817,016
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,817,016
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	See Attached	$ 224,362
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 224,362

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 210,467
Unemployment Compensation Insurance	
FICA Taxes	780,736
Employee Health Insurance	1,349,547
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Educational and Other Benefits	7,093
Life Insurance	1,625
Long Term Disability Insurance	17,751
Pension/Retirement Fund	463,230
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,830,449

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	19,756
Health Care Worker Background Check	2,149
(Indicate # of checks performed 72)	
Patient Background Checks	
LT Care Facilities Annual Licensure	
Renewal (Evanston, IL)	15,900
Memberships & Publications	15,010
Other Licenses and Fees	1,349
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,164

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,359
Seminar Expense	3,588
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,947

**See instructions.

Westminster Place
0012930
3/31/20
Detail of Professional Fees

Date	Vendor	Description of Expense	Expense
3/31/2020	A V POWELL & ASSOCIATES LLC	Actuarial Valuation	9,448.00
3/31/2020	Plante & Moran, PLLC	Auditing, Tax Return and Cost Report Preparer	6,589.00
3/31/2020	KEYNOTE CONSULTING, INC	Collection Agency (Adjusted on Page 5A)	232.00
3/31/2020	ABILITY NETWORK, INC.	Data Processing	12,076.00
3/31/2020	BASIS INTERNATIONAL LTD.	Data Processing	303.00
3/31/2020	CAREMERGE	Data Processing	2,700.00
3/31/2020	CDW GOVERNMENT INC	Data Processing	15,034.00
3/31/2020	Dude Solutions	Data Processing	7,044.00
3/31/2020	Healthcare Source	Data Processing	4,795.00
3/31/2020	IT'S NEVER 2 LATE	Data Processing	8,774.00
3/31/2020	KNOWBE4, INC.	Data Processing	1,490.00
3/31/2020	KRONOS	Data Processing	18,285.00
3/31/2020	MERIDIAN IT INC	Data Processing	8,190.00
3/31/2020	MIMECAST NORTH AMERICA, INC.	Data Processing	5,409.00
3/31/2020	NETSMART TECHNOLOGIES	Data Processing	17,954.00
3/31/2020	NEXTGEN HEALTHCARE, INC.	Data Processing	1,092.00
3/31/2020	NEXUM, INC.	Data Processing	13,309.00
3/31/2020	OmnigoSoftware LLC	Data Processing	944.00
3/31/2020	ONSHIFT, INC.	Data Processing	14,184.00
3/31/2020	PC CONNECTION TECHNOLOGIES	Data Processing	3,972.00
3/31/2020	PINNACLE SERVICES INC	Data Processing	5,354.00
3/31/2020	PROVINET SOLUTIONS	Data Processing	259.00
3/31/2020	RELIAS LEARNING LLC	Data Processing	10,726.00
3/31/2020	STATUS SOLUTIONS	Data Processing	2,357.00
3/31/2020	TELETECH CORPORATION	Data Processing	174.00
3/31/2020	TOUCHTOWN	Data Processing	4,491.00
3/31/2020	UNIFIED POWER	Data Processing	1,757.00
3/31/2020	VISUAL TOUCH POS SOLUTIONS LLC	Data Processing	6,669.00
3/31/2020	ZOHO	Data Processing	2,691.00
3/31/2020	GOULD & RATNER	Legal (See Attached)	13,282.00
3/31/2020	NOZARI LEGAL, LLC	Legal (See Attached)	4,680.00
3/31/2020	POLSINELLI	Legal (See Attached)	20,098.00
Total			224,362.00

Westminster Place
0012930
3/31/20
Detail of Legal Expense

Date	General Ledger Accounts	Vendor	Description of Expense	Allow Expense
9/23/2019	40-90-930-69810	Gould & Ratner	Legal Service For Employee Matter	190.00
2/21/2020	40-90-930-69810	Gould & Ratner	Legal Service For Employee Matter	504.00
1/16/2020	40-90-930-69810	Gould & Ratner	Legal Service For Employee Matter	942.00
2/21/2020	40-90-930-69810	Gould & Ratner	Legal Service For Employee Matter	1,048.00
5/20/2019	40-90-930-69810	Gould & Ratner	Legal Service For Employee Matter	3,814.00
3/31/2020	40-30-100-69810	Gould & Ratner	Legal Service For Employee Matter	727.00
6/13/2019	40-30-100-69810	Gould & Ratner	Legal Service For Employee Matter	464.00
5/20/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	67.00
6/13/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	68.00
8/20/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	139.00
12/17/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	303.00
10/17/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	320.00
7/19/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	437.00
9/23/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	538.00
2/21/2020	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	605.00
11/19/2019	40-90-930-69810	Gould & Ratner	Legal Service For HR General Matters	874.00
2/21/2020	40-90-100-69810	Gould & Ratner	Legal Service For Resident Matters	2,242.00
3/6/2020	40-90-930-69810	Nozari Legal, Llc	Legal Service For Employee Matter	4,680.00
6/5/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	1,825.00
6/25/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	1,237.00
6/24/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	698.00
7/11/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	1,419.00
7/24/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	4,785.00
8/8/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	609.00
8/16/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	580.00
9/19/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	464.00
9/19/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	1,940.00
10/10/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	204.00
11/5/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	269.00
12/12/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	334.00
10/10/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	682.00
12/14/2019	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	2,080.00
1/10/2020	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	358.00
1/9/2020	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	845.00
2/23/2020	40-30-100-69810	Polsinelli	Legal Service For Resident Matters	520.00
7/24/2019	40-30-100-69810	Polsinelli	Legal Services For General Administrative	94.00
8/16/2019	40-30-100-69810	Polsinelli	Legal Services For General Administrative	105.00
2/23/2020	40-30-100-69810	Polsinelli	Legal Services For General Administrative	1,050.00
Total				38,060.00

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 4/1/19 Ending: 3/31/20

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. $ **25,969** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **410,531**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **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: **Plante Moran PLLC**

(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.

PM STAFF - > COPY IN FROM TB FILE, IL MCD CR ENTRY TAB

PG 1 & 2					
IDPH License ID Number:	0012930				
Facility Name:	Westminster Place				
Street					
City					
Zip Code					
County					
Telephone Number:					
Fax #					
HFS ID Number:					
Date of Initial License for Current Owners:					
VOLUNTARY,NON-PROFIT					
Charitable Corp.					
Trust					
IRS Exemption Code					
PROPRIETARY					
Individual					
Partnership					
Corporation					
"Sub-S" Corp.					
Limited Liability Co.					
Trust					
Other					
Other					
GOVERNMENTAL					
State					
County					
Other					
Other					
Name:					
Telephone Number:					
Email Address:					
Beds at Beginning					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
Beds at End					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
Licensed Bed Days					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
MCD Census					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
Private Pay Census					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
All Other Census					
Skilled (SNF)					
Skilled Pediatric (SNF/PED)					
Intermediate (ICF)					
Intermediate/DD					
Sheltered Care (SC)					
ICF/DD 16 or Less					
Medicare Days	7312.00				
PG 3 & 4					
A. General Services	Salary/Wage	Supplies	Other	Reclass	Adjustment
Dietary	727,508	87,522	432,927	-	-
Food Purchase	-	675,327	-	-	-
Housekeeping	355,130	58,660	24,976	-	-
Laundry	112,497	36,480	6,551	-	-
Heat and Other Utilities	-	-	229,363	-	-
Maintenance	223,994	234,968	119,106	-	-
Other (specify):*	-	-	-	-	-
TOTAL General Services					
B. Health Care and Programs					
Medical Director	23828.00	0.00	0.00	0.00	0.00
Nursing and Medical Records	7415350.00	#######	#######	0.00	0.00
Therapy	0.00	11663.00	#######	0.00	0.00
Activities	287880.00	12616.00	14989.00	0.00	0.00
Social Services	236714.00	0.00	0.00	0.00	0.00
CNA Training	0.00	0.00	0.00	0.00	0.00
Program Transportation	142873.00	0.00	1520.00	0.00	0.00
Other (specify):*	0.00	0.00	0.00	0.00	0.00
TOTAL Health Care and Programs					
C. General Administration					
Administrative	189082.00	0.00	#######	0.00	#######
Directors Fees	0.00	0.00	0.00	0.00	0.00
Professional Services	0.00	0.00	#######	0.00	-232.00
Dues, Fees, Subscriptions & Promotions	0.00	0.00	54164.00	0.00	0.00
Clerical & General Office Expenses	661465.00	45166.00	#######	0.00	#######
Employee Benefits & Payroll Taxes	0.00	0.00	#######	0.00	0.00
Inservice Training & Education	0.00	0.00	0.00	0.00	0.00
Travel and Seminar	0.00	0.00	4947.00	0.00	0.00
Other Admin. Staff Transportation	0.00	0.00	0.00	0.00	0.00
Insurance-Prop.Liab.Malpractice	0.00	0.00	#######	0.00	0.00
Other (specify):*	0.00	0	28857	0	-28857
D. Ownership					
Depreciation	0.00	0.00	#######	0.00	#######
Amortization of Pre-Op. & Org.	0.00	0	0	0	0
Interest	0.00	0	0	0	0
Real Estate Taxes	0.00	0	0	0	0
Rent-Facility & Grounds	0.00	0	0	0	0
Rent-Equipment & Vehicles	0.00	0	26198	0	0
Other (specify):*	0.00	0	0	0	88214
TOTAL Ownership					
Ancillary Expense					
E. Special Cost Centers					
Medically Necessary Transportation	0.00	0	0	0	0
Ancillary Service Centers	0.00	0	0	0	0
Barber and Beauty Shops	0.00	0	0	0	0
Coffee and Gift Shops	0.00	0	0	0	0
Provider Participation Fee	0.00	0	410531	0	0
Other (specify):*	352854.00	15526	44460	0	-412840
PG 5 & 5A					
Day Care	0.00				
Other Care for Outpatients	0.00				
Governmental Sponsored Special Prograr	0.00				
Non-Patient Meals	0.00				
Telephone, TV & Radio in Resident Roon	0.00				
Rented Facility Space	0.00				
Sale of Supplies to Non-Patients	0.00				
Laundry for Non-Patients	0.00				
Non-Straightline Depreciation	-509455.00				
Interest and Other Investment Income	0.00				
Discounts, Allowances, Rebates & Refunds	0.00				
Non-Working Officer's or Owner's Salary	0.00				
Sales Tax	0.00				
Non-Care Related Interest	0.00				
Non-Care Related Owner's Transactions	0.00				
Personal Expenses (Including Transportati	0.00				
Non-Care Related Fees	0.00				
Fines and Penalties	-7414.00				
Entertainment	0.00				
Contributions	0.00				
Owner or Key-Man Insurance	0.00				
Special Legal Fees & Legal Retainers	0.00				
Malpractice Insurance for Individuals	0.00				
Bad Debt	-284439.00				
Fund Raising, Advertising and Promotiona	-28857.00				
Property Replacement Tax	0.00				
CNA Training for Non-Employees	0.00				
Yellow Page Advertising	0.00				
Other-Attach Schedule	-435662.00				
Non-Paid Workers-Attach Schedule*	0.00				
Donated Goods-Attach Schedule*	0.00				
Pre-Operating Expense	0.00				
Costs (Schedule VII)	-435903.00	VII-B			
Other- Attach Schedule	0.00				
PG5A Line 1	Non-SNF Relate	-19071	36		
PG5A Line 2	Community Eng	-3519	21		
PG5A Line 3	Clinic Services	-412840	43		
PG5A Line 4	Collections Exp	-232	19		
PG5A Line 5		0			
PG5A Line 6		0			
PG5A Line 7		0			
PG5A Line 8		0			
PG5A Line 9		0			
PG5A Line 10		0			
PG5A Line 11		0			
PG5A Line 12		0			
PG5A Line 13		0			
PG5A Line 14		0			
PG5A Line 15		0			
PG5A Line 16		0			
PG5A Line 17		0			
PG5A Line 18		0			
PG5A Line 19		0			
PG5A Line 20		0			
PG5A Line 21		0			
PG5A Line 22		0			
PG5A Line 23		0			
PG5A Line 24		0			
PG5A Line 25		0			
PG5A Line 26		0			
PG5A Line 27		0			
PG5A Line 28		0			
PG5A Line 29		0			
PG5A Line 30		0			
PG5A Line 31		0			
PG5A Line 32		0			
PG5A Line 33		0			
PG5A Line 34		0			
PG5A Line 35		0			
PG5A Line 36		0			
PG5A Line 37		0			
PG5A Line 38		0			
PG5A Line 39		0			
PG5A Line 40		0			
PG5A Line 41		0			
PG5A Line 42		0			
PG5A Line 43		0			
PG5A Line 44		0			
PG5A Line 45		0			
PG5A Line 46		0			
PG5A Line 47		0			
PG5A Line 48		0			
PG 16					
Licensed Occupational Therapist	V10A				
Licensed Occupational Therapist	0.00				
Licensed Occupational Therapist	0.00				
Licensed Occupational Therapist	27740.00				
Licensed Occupational Therapist	541727.00				
Licensed Occupational Therapist	4721.00				
Licensed Speech and Language	V10A				
Licensed Speech and Language	0.00				
Licensed Speech and Language	0.00				
Licensed Speech and Language	2117.00				
Licensed Speech and Language	101230.00				
Licensed Speech and Language	882.00				
Licensed Recreational Therapist	V10A				
Licensed Recreational Therapist	0.00				
Licensed Recreational Therapist	0.00				
Licensed Recreational Therapist	0.00				
Licensed Recreational Therapist	0.00				
Licensed Recreational Therapist	0.00				
Licensed Physical Therapist	V10A				
Licensed Physical Therapist	0.00				
Licensed Physical Therapist	0.00				
Licensed Physical Therapist	39649.00				
Licensed Physical Therapist	695310.00				
Licensed Physical Therapist	6060.00				
Habilitation	V39				
Habilitation	0.00				
Habilitation	0.00				
Habilitation	0.00				
Habilitation	0.00				
Habilitation	0.00				
Pharmacy	V39				
Pharmacy	0.00				
Pharmacy	0.00				
Pharmacy	0.00				
Pharmacy	0.00				
Pharmacy	0.00				
LAB/RADIOLOGY	V39				
LAB/RADIOLOGY	0.00				
LAB/RADIOLOGY	0.00				
LAB/RADIOLOGY	0.00				
LAB/RADIOLOGY	0.00				
LAB/RADIOLOGY	0.00				
BILLABLE SUPPLIES/IV THERAPY/ETC	V39				
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00				
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00				
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00				
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00				
BILLABLE SUPPLIES/IV THERAPY/ETC	0.00				
PG 17					
Cash on Hand and in Banks	15552532.00				
Cash-Patient Deposits	0.00				
Accounts & Short-Term Notes Receivable	2860265.00				
Patients (less allowance	490048.00				
Supply Inventory (priced at	0.00				
Short-Term Investments	0.00				
Prepaid Insurance	331990.00				
Other Prepaid Expenses	461538.00				
Accounts Receivable (owners or related p	0.00				
Other(specify):	0.00				
Long-Term Notes Receivable	0.00				
Long-Term Investments	18918306.00				
Land	5875916.00				
Buildings, at Historical Cost	176284454.00				
Leasehold Improvements, at Historical Co	0.00				
Equipment, at Historical Cost	24766401.00				
Accumulated Depreciation (book method	-124094348.00				
Deferred Charges	0.00				
Organization & Pre-Operating Costs	0.00				
Accumulated Amortization - Organization	0.00				
Restricted Funds	0.00				
Other Long-Term Assets (specify):	854743.00				
Other(specify):	1298661.00				
Accounts Payable	4437724.00				
Officer's Accounts Payable	0.00				
Accounts Payable-Patient Deposits	0.00				
Short-Term Notes Payable	463639.00				
Accrued Salaries Payable	2787927.00				
Accrued Taxes Payable	343883.00				
Accrued Real Estate Taxes(Sch.IX-B)	0.00				
Accrued Interest Payable	157020.00				
Deferred Compensation	48827.00				
Federal and State Income Taxes	0.00				
Other 1	1077064.00				
Other 2	4997420.00				
Long-Term Notes Payable	0.00				
Mortgage Payable	0.00				
Bonds Payable	11446209.00				
Deferred Compensation	0.00				
Other 1	75804688.00				
Other 2	4388778.00				
PG 18					
Balance at Beginning of Year, as Previou	13152699.00				
Restatement 1	0.00	0			
Restatement 2	0.00	0			
Restatement 3	0.00	0			
A. Additions (deductions):					
Aquisitions of Pooled Companies	0.00				
Proceeds from Sale of Stock	0.00				
Stock Options Exercised	0.00				
Contributions and Grants	0.00				
Expenditures for Specific Purposes	0.00				
Dividends Paid or Other Distributions to O	0.00				
Donated Property, Plant, and Equipment	0.00				
Other (describe)	0.00	0			
Other (describe)	0.00	0			
B. Transfers (Itemize):					
Transfer1	-941176.00	ILU & ALU	net asset activity for the year		
Transfer2	0.00	0			
Transfer3	0.00	0			
Transfer4	0.00	0			
Transfer5	0.00	0			

PG 19

Gross Revenue -- All Levels of Care	26268885.00	
Discounts and Allowances for all Levels	-2461058.00	
Day Care	0.00	
Other Care for Outpatients	0.00	
Therapy	2494471.00	
Oxygen	0.00	
Payments for Education	0.00	
Other Government Grants	0.00	
CNA Training Reimbursements	0.00	
Gift and Coffee Shop	0.00	
Barber and Beauty Care	0.00	
Non-Patient Meals	0.00	
Telephone, Television and Radio	0.00	
Rental of Facility Space	19071.00	
Sale of Drugs	14560.00	
Sale of Supplies to Non-Patients	0.00	
Laboratory	0.00	
Radiology and X-Ray	0.00	
Other Medical Services	39932.00	
Laundry	0.00	
Contributions	1471909.00	
Interest and Other Investment Income***	45361.00	
Settlement Income (Insurance, Legal, Etc	0.00	
OTHER1	198231.00	AL/IL
OTHER2	0.00	Misc Revenue
General Services	3325009.00	
Health Care	10698347.00	
General Administration	6613309.00	
Ownership	1687570.00	
Special Cost Centers	412840.00	
Provider Participation Fee	410531.00	
OTHER1	0.00	0
OTHER2	0.00	0
OTHER3	0.00	0
Income Taxes	0.00	
Medicaid - Net Inpatient Revenue	420807.00	
Private Pay - Net Inpatient Revenue	19694812.00	
Medicare - Net Inpatient Revenue	3117793.00	
Other-(specify)	574415.00	ALL OTHER SNF/SCF IP REVENUE
Other-(specify)	0.00	0

PG 20	Worked	Accrued	Wages
Director of Nursing	1718.00	1970	143113
Assistant Director of Nursing	3768.00	4184	216519
Registered Nurses	77982.00	85319	3670291
Licensed Practical Nurses	12742.00	13724	427545
CNAs & Orderlies	148562.00	161367	2908731
CNA Trainees	0.00	0.00	0.00
Licensed Therapist	0.00	0.00	0.00
Rehab/Therapy Aides	0.00	0.00	0.00
Activity Director	1761.00	2019	55766
Activity Assistants	10393.00	12095	232114
Social Service Workers	5428.00	6215	236714
Dietician	0.00	0.00	0.00
Food Service Supervisor	4428.00	4907	101500
Head Cook	6126.00	6782	124420
Cook Helpers/Assistants	27921.00	30861	419178
Dishwashers	5468.00	6200.00	82410.00
Maintenance Workers	4058.00	4545	112048
Housekeepers	23643.00	26084	355130
Laundry	7423.00	8390	112497
Administrator	1703.00	2030	189082
Assistant Administrator	0.00	0	0
Other Administrative	11631.00	13283.00	#######
Office Manager	0.00	0.00	0.00
Clerical	7807.00	8618	170600
Vocational Instruction	0.00	0.00	0.00
Academic Instruction	0.00	0.00	0.00
Medical Director	159.00	178.00	23828.00
Qualified MR Prof. (QMRP)	0.00	0.00	0.00
Resident Services Coordinator	0.00	0.00	0.00
Habilitation Aides (DD Homes)	0.00	0.00	0.00
Medical Records	1384.00	1587	49151
Other Health Care(specify)	13724.00	15414.00	#######
Other(specify)	3734.00	4671	352854
Dietary Consultant			
Medical Director			
Medical Records Consultant			
Nurse Consultant			
Pharmacist Consultant			
Physical Therapy Consultant			
Occupational Therapy Consultant			
Respiratory Therapy Consultant			
Speech Therapy Consultant			
Activity Consultant			
Social Service Consultant			
Other(specify)			
Other(specify)			
Other(specify)			

PAGE 17 CTB

Cash on Hand and in Banks
Cash-Patient Deposits
Accounts & Short-Term Notes Receivable-
Patients (less allowance
Supply Inventory (priced at
Short-Term Investments
Prepaid Insurance
Other Prepaid Expenses
Accounts Receivable (owners or related parties)
Other(specify):
Long-Term Notes Receivable
Long-Term Investments
Land
Buildings, at Historical Cost
Leasehold Improvements, at Historical Cost
Equipment, at Historical Cost
Accumulated Depreciation (book methods)
Deferred Charges
Organization & Pre-Operating Costs
Accumulated Amortization - Organization & Pre-Operating Costs
Restricted Funds
Other Long-Term Assets (specify):
Other(specify):
Accounts Payable
Officer's Accounts Payable
Accounts Payable-Patient Deposits
Short-Term Notes Payable
Accrued Salaries Payable
Accrued Taxes Payable
Accrued Real Estate Taxes(Sch.IX-B)
Accrued Interest Payable
Deferred Compensation
Federal and State Income Taxes
Other 1
Other 2
Long-Term Notes Payable
Mortgage Payable
Bonds Payable
Deferred Compensation
Other 1
Other 2
CTB Equity

Record	Facility ID	Facility Name	Year	Location	City	County	Company	SNF Beds	SNF PED Beds	ICF Beds	ICF DD Beds	SC Beds	DD 16 Beds	Total Beds	Bed Days Available	Medicare Beds	Medicare Days	SNF - Medicaid Days	SNF - Private Days	SNF - Other Days	SNF - Total Days
	0012930	Westminster Place	2020		Evanston	Cook		105		99		51		255	93,330	105	7,512	2,726	14,769	8,815	26,310

SNF PED - Medicaid Days	SNF PED - Private Days	SNF PED - Other Days	SNF PED - Total Days	ICF - Medicaid Days	ICF - Private Days	ICF - Other Days	ICF - Total Days	ICF DD - Medicaid Days	ICF DD - Private Days	ICF DD - Other Days	ICF DD - Total Days	SC - Medicaid Days	SC - Private Days	SC - Other Days	SC - Total Days	DD16 - Medicaid Days	DD16 - Private Days	DD16 - Other Days	DD16 - Total Days	Total Medicaid Days	Total Private Days	Total Other Days	Total Days
					31,185		31,185													2,726	45,954	8,815	57,495

1 - 1	1 - 2	1 - 3	1 - 8	2 - 2	2 - 8	3 - 1	3 - 2	3 - 3	3 - 8	4 - 1	4 - 2	4 - 3	4 - 8	5 - 3	5 - 8	6 - 1	6 - 2	6 - 3	6 - 8	7 - 1	7 - 2	7 - 3	7 - 8	9 - 1	9 - 2	9 - 3	9 - 8
797,508	87,522	439,927	1,247,957	675,327	675,327	355,130	58,660	24,976	438,766	112,497	36,480	6,551	155,528	229,363	229,363	223,994	234,968	119,106	578,068	0	0	0	0	23,828	0	0	23,828

10 - 1	10 - 2	10 - 3	10 - 8	10a - 1	10a - 2	10a - 3	10a - 8	11 - 1	11 - 2	11 - 3	11 - 8	12 - 1	12 - 2	12 - 3	12 - 8	13 - 1	13 - 2	13 - 3	13 - 8	14 - 1	14 - 2	14 - 3	14 - 8	15 - 1	15 - 2	15 - 3	15 - 8
7,405,350	494,493	728,184	8,627,997	0	11,663	1,338,267	1,349,930	287,880	12,626	14,989	315,485	236,714	0	0	236,714	0	0	0	0	142,873	0	1,520	144,393	0	0	0	0

17 - 1	17 - 2	17 - 3	17 - 8	18 - 3	18 - 8	19 - 3	19 - 8	20 - 3	20 - 8	21 - 1	21 - 2	21 - 3	21 - 8	22 - 3	22 - 8	23 - 3	23 - 8	24 - 3	24 - 8	25 - 2	25 - 3	25 - 8	26 - 3	26 - 8	27 - 1	27 - 2	27 - 3	27 - 8
189,082	0	1,827,016	1,462,910	0	0	224,362	224,130	54,164	54,164	661,465	45,166	497,864	879,123	2,830,449	2,830,449	0	0	4,047	4,047	0	0	0	289,937	289,937	0	0	####	0

30 - 3	30 - 8	31 - 3	31 - 8	32 - 3	32 - 8	33 - 3	33 - 8	34 - 3	34 - 8	35 - 3	35 - 8	36 - 3	36 - 8	38 - 1	38 - 2	38 - 3	38 - 8	39 - 1	39 - 2	39 - 3
1,661,379	1,151,917	0	0	0	0	0	0	0	0	26,198	26,198	0	####	0	0	0	0	0	0	0

50 - 46 - 02	50 - 46 - 03	50 - 14 - 01	50 - 14 - 02	50 - 14 - 03	50 - 14 - 04	NULL 02	50 - 47 - 01	50 - 47 - 02	50 - 47 - 03	50 - 15 - 01	50 - 15 - 02	50 - 15 - 03	50 - 15 - 04	NULL 03	50 - 48 - 01	50 - 48 - 02	50 - 48 - 03	50 - 16 - 01	50 - 16 - 02	50 - 16 - 03	50 - 16 - 04
0		6,126	6,782	124,420	18.35		0	0		27,921	30,880	419,178	13.58		0	0		5,488	6,200	82,410	13.29

50 - 17 - 01	50 - 17 - 02	50 - 17 - 03	50 - 17 - 04	50 - 49 - 01	50 - 49 - 02	50 - 18 - 01	50 - 18 - 02	50 - 18 - 03	50 - 18 - 04	50 - 19 - 01	50 - 19 - 02	50 - 19 - 03	50 - 19 - 04	50 - 20 - 01	50 - 20 - 02	50 - 20 - 03	50 - 20 - 04	50 - 21 - 01	50 - 21 - 02	50 - 21 - 03	50 - 21 - 04
4,058	4,545	112,048	24.65			23,643	26,084	355,130	13.61	7,423	8,390	112,497	13.41	1,703	2,030	189,082	93.14	0	0	0	

50 - 22 - 01	50 - 22 - 02	50 - 22 - 03	50 - 22 - 04	50 - 23 - 01	50 - 23 - 02	50 - 23 - 03	50 - 23 - 04	50 - 24 - 01	50 - 24 - 02	50 - 24 - 03	50 - 24 - 04	50 - 25 - 01	50 - 25 - 02	50 - 25 - 03	50 - 25 - 04	50 - 26 - 01	50 - 26 - 02	50 - 26 - 03	50 - 26 - 04	50 - 27 - 01	50 - 27 - 02	50 - 27 - 03	50 - 27 - 04
11,031	13,283	490,865	36.95	0	0	0		7,807	8,618	170,600	19.8	0	0	0		0	0	0		159	178	23,828	133.87

50 - 50 - 01	50 - 50 - 02	50 - 50 - 03	50 - 28 - 01	50 - 28 - 02	50 - 28 - 03	50 - 28 - 04	50 - 51 - 01	50 - 51 - 02	50 - 51 - 03	50 - 29 - 01	50 - 29 - 02	50 - 29 - 03	50 - 29 - 04	50 - 52 - 01	50 - 52 - 02	50 - 52 - 03	50 - 30 - 01	50 - 30 - 02	50 - 30 - 03	50 - 30 - 04
19	1,305	10-3	0	0	0		0	0	0	0	0	0		6,773	187,969	10-3	0	0	0	

50 - 31 - 01	50 - 31 - 02	50 - 31 - 03	50 - 31 - 04	50 - 53 - 01	50 - 53 - 02	NULL 04	50 - 32 - 01	50 - 32 - 02	50 - 32 - 03	50 - 32 - 04	NULL 05	50 - 33 - 01	50 - 33 - 02	50 - 33 - 03	50 - 33 - 04	50 - 34 - 01	50 - 34 - 02	50 - 34 - 03	50 - 34 - 04
1,384	1,587	49,151	30.97	6,792	189,274		13,794	15,414	254,819	16.53		3,734	4,871	352,854	75.54	389,593	420,443	10,799,175	25.59