

Facility Name & ID Number Westminster Place

0012930 Report Period Beginning: 04/01/2013 Ending: 03/31/2014

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,325	1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5	51	Sheltered Care (SC)	51	18,615	5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,075	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	121	25,937	6,330	32,388	8
9	SNF/PED					9
10	ICF		32,059		32,059	10
11	ICF/DD					11
12	SC		13,505		13,505	12
13	DD 16 OR LESS					13
14	TOTALS	121	71,501	6,330	77,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.75%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Physical Therapy, Occupational Therapy, Speech Therapy, Radiology & Pharmacy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 10/01/1922

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 105 and days of care provided 6,330

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 03/31/2014 Fiscal Year: 03/31/2014

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	864,661	141,353	(56,730)	949,284		949,284	949,284		1	
2	Food Purchase		836,921		836,921		836,921	(837,540)	(619)	2	
3	Housekeeping	317,454	37,717	170,346	525,517		525,517	525,517		3	
4	Laundry	59,894	6,959	28,447	95,300		95,300	95,300		4	
5	Heat and Other Utilities			381,449	381,449		381,449	(794)	380,655	5	
6	Maintenance	410,536	81,012	416,899	908,447		908,447	908,447		6	
7	Other (specify):*									7	
8	TOTAL General Services	1,652,545	1,103,962	940,411	3,696,918		3,696,918	(838,334)	2,858,584	8	
	B. Health Care and Programs										
9	Medical Director	943,008			943,008		943,008	943,008		9	
10	Nursing and Medical Records	7,665,796	437,482	1,781,196	9,884,474		9,884,474	9,884,474		10	
10a	Therapy									10a	
11	Activities	245,912	10,326	18,593	274,831		274,831	274,831		11	
12	Social Services	334,238	335	44	334,617		334,617	334,617		12	
13	CNA Training									13	
14	Program Transportation	73,405	638		74,043		74,043	74,043		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	9,262,359	448,781	1,799,833	11,510,973		11,510,973	11,510,973		16	
	C. General Administration										
17	Administrative	56,471	577		57,048		57,048	57,048		17	
18	Directors Fees									18	
19	Professional Services			16,636	16,636		16,636	16,636		19	
20	Dues, Fees, Subscriptions & Promotions			66,480	66,480		66,480	66,480		20	
21	Clerical & General Office Expenses	40,682	197,412	89,007	327,101		327,101	327,101		21	
22	Employee Benefits & Payroll Taxes			1,460,922	1,460,922		1,460,922	1,460,922		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			18,874	18,874		18,874	18,874		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			49,295	49,295		49,295	49,295		26	
27	Other (specify):*									27	
28	TOTAL General Administration	97,153	197,989	1,701,214	1,996,356		1,996,356	1,996,356		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	11,012,057	1,750,732	4,441,458	17,204,247		17,204,247	(838,334)	16,365,913	29	

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Westminster Place

#0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			735,660	735,660	735,660		735,660				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			735,660	735,660	735,660		735,660				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	622,098	13,950	66,836	702,884	702,884		702,884				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			457,267	457,267	457,267		457,267				42
43	Other (specify):* AL/IL/Marketing	6,391,795	564,995	17,288,854	24,245,644	24,245,644	(24,245,644)					43
44	TOTAL Special Cost Centers	7,013,893	578,945	17,812,957	25,405,795	25,405,795	(24,245,644)	1,160,151				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	18,025,950	2,329,677	22,990,075	43,345,702	43,345,702	(25,083,978)	18,261,724				45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning: 04/01/2013

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(837,540)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,739)			24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,246,438)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,170,717)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (25,170,717)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Westminster Place

ID# 0012930

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	AL Salaries	\$ (2,998,480)	43	1
2	IL Salaries	(3,300,206)	43	2
3	Marketing Salaries	1,300	43	3
4	Fitness Salaries	(87,881)	43	4
5	Beauty Shop Salaries	(6,528)	43	5
6	AL Supplies	(172,238)	43	6
7	IL Supplies	(389,774)	43	7
8	Marketing Supplies	(1,459)	43	8
9	Fitness Supplies	(1,524)	43	9
10	AL Other	(4,747,205)	43	10
11	IL Other	(12,496,469)	43	11
12	Marketing Other	(35,874)	43	12
13	Fitness Other	(9,306)	43	13
14	Telephone	(794)	05	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,246,438)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westminster Place# 0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(837,540)	0	0	0	0	0	0	0	0	0	0	(837,540)	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	(794)	0	0	0	0	0	0	0	0	0	0	(794)	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	(838,334)	0	(838,334)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(838,334)	0	(838,334)	29									

STATE OF ILLINOIS

Facility Name & ID Number Westminster Place# 0012930

Report Period Beginning:

04/01/2013 Ending:

Summary B

03/31/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(24,245,644)	0	0	0	0	0	0	0	0	0	0	(24,245,644)	43
44	TOTAL Special Cost Centers	(24,245,644)	0	0	0	0	0	0	0	0	0	0	(24,245,644)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(25,083,978)	0	0	0	0	0	0	0	0	0	0	(25,083,978)	45

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning: 04/01/2013 Ending: 03/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplement	100%	See Page 6 Supplement		See Page 6 Supplement		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Westminster Place

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	See Attached Board of Directors		Balmoral Care Center	Lake Forest				1
2			James C. King Home	Evanston				2
3			Mooring Health Center	Arlington Heights				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Westminster Place

#

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Westminster Place

0012930 Report Period Beginning: 04/01/2013

Ending: 3/31/2014

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009 _____	8	FOR BHF USE ONLY			
	2010 _____	9				
	2011 _____	10			13 FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2012 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2013 _____	12			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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westminster Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012930

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Westminster Place

0012930 Report Period Beginning:

04/01/2013 Ending:

03/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Assisted Living
Independent Living

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>			\$ <u>8,252</u>	1
2					2
3	TOTALS			\$ <u>8,252</u>	3

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

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

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

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	OTIS KOGLIN WILSON ARCHITECTS INC.	2011	\$ 9,589	\$		\$	\$	\$	37
38	OTIS KOGLIN WILSON ARCHITECTS INC	2011	17,850						38
39	DALLIA FLOOR & WALL CO INC	2011	8,780						39
40	TESTING SERVICE CORPORATION	2011	4,156						40
41	ERIKSSON ENGINEERING ASSOC LTD.	2011	18,190						41
42	INTERIOR DESIGN ASSOCIATES INC	2011	2,500						42
43	OTIS KOGLIN WILSON ARCHITECTS INC	2011	44,566						43
44	DALLIA FLOOR & WALL CO INC	2011	17,560						44
45	BOELTER COMPANIES CORPORATE OFFICE	2011	6,000						45
46	OTIS KOGLIN WILSON ARCHITECTS INC	2011	37,289						46
47	INTERIOR DESIGN ASSOCIATES INC	2011	7,500						47
48	ILLINOIS DEPARTMENT OF PUBLIC HEALTH PLA	2011	9,600						48
49	TESTING SERVICE CORPORATION	2011	1,250						49
50	DALLIA FLOOR & WALL CO INC	2012	10,536						50
51	Metropolitan Water Reclamation	2012	4,000						51
52	INTERIOR DESIGN ASSOCIATES INC	2012	12,387						52
53	ERIKSSON ENGINEERING ASSOC LTD.	2012	7,012						53
54	ERIKSSON ENGINEERING ASSOC LTD.	2012	510						54
55	LAKOTA GROUP	2012	30,056						55
56	OTIS KOGLIN WILSON ARCHITECTS INC	2012	9,903						56
57	OTIS KOGLIN WILSON ARCHITECTS INC	2012	45,510						57
58	ERIKSSON ENGINEERING ASSOC LTD.	2012	122						58
59	ILLINOIS DEPARTMENT OF PUBLIC HEALTH PLA	2012	9,600						59
60	DALLIA FLOOR & WALL CO INC	2012	14,926						60
61	INTERIOR DESIGN ASSOCIATES INC	2012	2,026						61
62	ELDERLIFE DEVELOPMENT LTD	2012	3,818						62
63	OTIS KOGLIN WILSON ARCHITECTS INC	2012	8,264						63
64	Pinnacle Services Inc	2012	985						64
65	ERIKSSON ENGINEERING ASSOC LTD.	2012	3,986						65
66	ERIKSSON ENGINEERING ASSOC LTD.	2012	4,450						66
67	ERIKSSON ENGINEERING ASSOC LTD.	2012	57						67
68	OTIS KOGLIN WILSON ARCHITECTS INC	2012	1,387						68
69	INTERIOR DESIGN ASSOCIATES INC	2012	951						69
70	TOTAL (lines 4 thru 69)		\$ 19,352,106	\$		\$	\$	\$	70

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

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning:

04/01/2013

Ending:

03/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 21,830,364	\$		\$	\$	\$	1
2	INTERIOR DESIGN ASSOCIATES INC	2013	2,500		20				2
3	GREENLEAF CABINETS, INC.	2013	30,610		20				3
4	GREENLEAF CABINETS, INC.	2013	20,160		20				4
5	GREENLEAF CABINETS, INC.	2013	53,760		20				5
6	INTERIOR DESIGN ASSOCIATES INC	2013	2,629		20				6
7	INTERIOR DESIGN ASSOCIATES INC	2013	3,194		20				7
8	INTERIOR DESIGN ASSOCIATES INC	2013	2,629		20				8
9	INTERIOR DESIGN ASSOCIATES INC	2013	3,459		20				9
10	INTERIOR DESIGN ASSOCIATES INC	2013	57,326		20				10
11	LAKOTA GROUP	2013	6,830		20				11
12	Power Construction Company	2013	495,893		20				12
13	ERIKSSON ENGINEERING ASSOC LTD.	2013	1,240		20				13
14	INTERIOR DESIGN ASSOCIATES INC	2013	3,630		20				14
15	OKW Architects, Inc.	2013	6,405		20				15
16	Power Construction Company	2013	678,275		20				16
17	ERIKSSON ENGINEERING ASSOC LTD.	2013	499		20				17
18	LAKOTA GROUP	2013	1,893		20				18
19	INTERIOR DESIGN ASSOCIATES INC	2013	4,443		20				19
20	Otis,Koglin, Wilson 32226	2013	41,200		20				20
21	Otis,Koglin, Wilson 32229	2013	67,660		20				21
22	Otis,Koglin, Wilson 32228	2013	5,940		20				22
23	Interior Design Assoc 23605	2013	65,045		20				23
24	LAKOTA GROUP	2013	4,996		20				24
25	F E MORAN INC	2013	17,475		20				25
26	PINNACLE SERVICES INC	2013	3,967		20				26
27	Eriksson Engineering Assoc	2013	753		20				27
28	Power Construction Company	2013	109,273		20				28
29	THE STATE FIRE MARSHALL	2013	30		20				29
30	OKW ARCHITECTS INC	2013	1,416		20				30
31	AtOMATIC MECHANICAL	2014	23,547		20				31
32					20				32
33	Financial Statement Depreciation			618,069	20	618,069		12,680,557	33
34	TOTAL (lines 1 thru 33)		\$ 23,547,041	\$ 618,069		\$ 618,069	\$	\$ 12,680,557	34

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

Facility Name & ID Number Westminster Place

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 23,547,041	\$ 618,069		\$ 618,069	\$	\$ 12,680,557	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 23,547,041	\$ 618,069		\$ 618,069	\$	\$ 12,680,557	34

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

Facility Name & ID Number Westminster Place

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 23,547,041	\$ 618,069		\$ 618,069	\$	\$ 12,680,557	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 23,547,041	\$ 618,069		\$ 618,069	\$	\$ 12,680,557	34

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

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	\$ 6,604,456	\$	\$	\$		\$	71
72	Current Year Purchases	88,119						72
73	Fully Depreciated Assets							73
74	Depreciation from F/S		117,591	117,591			4,093,403	74
75	TOTALS	\$ 6,692,575	\$ 117,591	\$ 117,591	\$		\$ 4,093,403	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 30,247,868	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 735,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 735,660	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 16,773,960	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted Living	\$ 32,697,085	\$ 1,018,384	\$ 21,674,852	86
87	Independent Living	99,576,456	3,749,053	53,785,438	87
88					88
89					89
90					90
91	TOTALS	\$ 132,273,541	\$ 4,767,437	\$ 75,460,290	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Westminster Place # 0012930 Report Period Beginning: 04/01/2013 Ending: 03/31/2014
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Westminster Place only hired CNAs that are already certified.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-1	hrs	\$	209,960		\$			\$	209,960	1
2	Licensed Speech and Language Development Therapist	39-1	hrs		20,657						20,657	2
3	Licensed Recreational Therapist	39-1	hrs		73,377						73,377	3
4	Licensed Physical Therapist	39-1	hrs		318,104						318,104	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Health Pro Management/Medical Supplies</u>							65,718			65,718	12
13	Other (specify):											13
14	TOTAL			\$	622,098		\$	65,718	\$		687,816	14

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

Facility Name & ID Number Westminster Place# 0012930Report Period Beginning: 04/01/2013Ending: 03/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 03/31/2014

(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	\$ 2,928,992	\$	1
2	Cash-Patient Deposits	1,916,289		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>362,000</u>)	2,396,742		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	10,063,581		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,229,250		7
8	Accounts Receivable (owners or related parties)	3,516,975		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,051,829	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	110,844,106		12
13	Land	30,188,849		13
14	Buildings, at Historical Cost	374,005,930		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	48,378,165		16
17	Accumulated Depreciation (book methods)	(193,403,860)		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 (spec <u>SEE ATTACHED</u>)	157,348,242		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 527,361,432	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 549,413,261	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,807,319	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,760,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	218,894		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>SEE ATTACHED</u>	8,578,784		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 26,364,997	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	63,900,000		39
40	Mortgage Payable			40
41	Bonds Payable	44,450,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Entrance Fees</u>	6,432,168		43
44	<u>Apt. & Congregate</u>	229,892,549		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 344,674,717	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 371,039,714	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 178,373,547	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 549,413,261	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 38,884,665	1
2	Restatements (describe):		2
3	Net Income Reconciliation to consolidated Balance Sheet	138,067,980	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 176,952,645	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,420,902	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)	\$ 1,420,902	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 178,373,547	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westminster Place# 0012930Report Period Beginning: 04/01/2013Ending: 03/31/2014

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,050,749	1
2	Discounts and Allowances for all Levels	(3,368,638)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,682,111	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,482,625	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,482,625	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	48,057	12
13	Barber and Beauty Care	298,560	13
14	Non-Patient Meals	837,540	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,900	16
17	Sale of Drugs	2,104,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	81	20
21	Other Medical Services	3,143	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,296,150	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	125,625	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125,625	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>SEE ATTACHED</u>	32,180,093	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,180,093	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 44,766,604	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,696,918	31
32	Health Care	11,510,973	32
33	General Administration	1,996,356	33
B. Capital Expense			
34	Ownership	735,660	34
C. Ancillary Expense			
35	Special Cost Centers	25,405,795	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 43,345,702	40
41	Income before Income Taxes (line 30 minus line 40)**	1,420,902	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,420,902	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	5,020,571	45
46	Medicare - Net Inpatient Revenue	1,404,374	46
47	Other-(specify) <u>Amortization/Fellowship/Insurance</u>	257,166	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,682,111	49

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

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

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

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

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	5,802	7,233	\$ 502,537	\$ 69.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	74,016	81,934	2,891,936	35.30	3
4	Licensed Practical Nurses	23,278	25,548	558,535	21.86	4
5	CNAs & Orderlies	143,099	158,726	2,038,170	12.84	5
6	CNA Trainees					6
7	Licensed Therapist	15,522	17,260	621,427	36.00	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	17,901	20,210	332,102	16.43	10
11	Social Service Workers	9,890	10,768	322,931	29.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,631	36,956	605,590	16.39	15
16	Dishwashers					16
17	Maintenance Workers	18,324	21,000	404,041	19.24	17
18	Housekeepers	35,990	39,794	426,304	10.71	18
19	Laundry	3,216	3,502	38,230	10.92	19
20	Administrator	28,369	30,129	1,410,344	46.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	780	877	19,483	22.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Pharmacy</u>	9,927	11,042	397,651	36.01	32
33	Other(specify) <u>AL/IL</u>	319,713	356,154	7,456,670	20.94	33
34	TOTAL (lines 1 - 33)	740,458	821,133	\$ 18,025,951 *	\$ 21.95	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	monthly	14,700	10-3	39
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify) <u>Medical Services</u>	monthly	37,283	10-3	46
47				47	
48				48	
49	TOTAL (lines 35 - 48)	\$	51,983		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,446	\$ 89,363	10-3	50
51	Licensed Practical Nurses	558	23,947	10-3	51
52	Certified Nurse Assistants/Aides	2,447	58,472	10-3	52
53	TOTAL (lines 50 - 52)	4,451	\$ 171,782		53

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

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

Facility Name & ID Number Westminster Place

0012930

Report Period Beginning: 04/01/2013

Ending: 03/31/2014

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 450,000
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 837,540
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.