

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 042614

Facility Name: Golfview Developmental Center, Inc.

Address: 9555 Golfview Road Des Plaines 60616
Number City Zip Code

County: Cook

Telephone Number: (847)827-6628 Fax # (847)827-0948

HFS ID Number:

Date of Initial License for Current Owners: 11/17/97

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	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: Kenneth Pinsky Telephone Number: (847)267-9600
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 1/1/11 to 12/31/11
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)	Warady & Davis LLP 1717 Deerfield Road, Ste 300 South, Deerfield, IL 60015	
	(Telephone)	(847)267-9600	Fax # (847)267-9696
	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		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center, Inc.

042614 Report Period Beginning: 1/1/11 Ending: 12/31/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	135	Intermediate/DD	135	49,275	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	48,039			48,039	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,039			48,039	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.49%

D. How many bed-hold days during this year were paid by the Department? 662 (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)

N/A

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 11/17/97

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/17/97 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	Golfview Developmental Center, Inc.	#	042614	Report Period Beginning:	1/1/11	Ending:	12/31/11
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	253,650	36,742	8,887	299,279		299,279		299,279			1
2	Food Purchase		294,690		294,690		294,690		294,690			2
3	Housekeeping	304,263	62,979		367,242		367,242		367,242			3
4	Laundry	29,150	10,381	358	39,889		39,889		39,889			4
5	Heat and Other Utilities			201,916	201,916		201,916		201,916			5
6	Maintenance	56,662	30,898	301,012	388,572		388,572	(163,767)	224,805			6
7	Other (specify):* Workshop Expense			1,964,472	1,964,472		1,964,472		1,964,472			7
8	TOTAL General Services	643,725	435,690	2,476,645	3,556,060		3,556,060	(163,767)	3,392,293			8
	B. Health Care and Programs											
9	Medical Director			16,391	16,391		16,391		16,391			9
10	Nursing and Medical Records	2,234,553	47,851	8,940	2,291,344		2,291,344		2,291,344			10
10a	Therapy			3,454	3,454		3,454		3,454			10a
11	Activities	92,720	24,988	2,418	120,126		120,126		120,126			11
12	Social Services			11,609	11,609		11,609		11,609			12
13	CNA Training	86,225			86,225		86,225		86,225			13
14	Program Transportation					29,256	29,256		29,256			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,413,498	72,839	42,812	2,529,149	29,256	2,558,405		2,558,405			16
	C. General Administration											
17	Administrative	174,793		384,387	559,180		559,180	(384,387)	174,793			17
18	Directors Fees											18
19	Professional Services			178,348	178,348		178,348	27,775	206,123			19
20	Dues, Fees, Subscriptions & Promotions			45,039	45,039		45,039	(15,407)	29,632			20
21	Clerical & General Office Expenses	114,767	37,697	188,707	341,171		341,171	25	341,196			21
22	Employee Benefits & Payroll Taxes			723,989	723,989		723,989		723,989			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,690	6,690		6,690		6,690			24
25	Other Admin. Staff Transportation			39,008	39,008	(29,256)	9,752		9,752			25
26	Insurance-Prop.Liab.Malpractice			85,369	85,369		85,369	42,944	128,313			26
27	Other (specify):*											27
28	TOTAL General Administration	289,560	37,697	1,651,537	1,978,794	(29,256)	1,949,538	(329,050)	1,620,488			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,346,783	546,226	4,170,994	8,064,003		8,064,003	(492,817)	7,571,186			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			58,173	58,173		58,173	274,574	332,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(63,346)	(63,346)		(63,346)	480,526	417,180			32
33	Real Estate Taxes							315,946	315,946			33
34	Rent-Facility & Grounds			1,186,095	1,186,095		1,186,095	(1,186,095)				34
35	Rent-Equipment & Vehicles			62,669	62,669		62,669	(5,005)	57,664			35
36	Other (specify):*											36
37	TOTAL Ownership			1,243,591	1,243,591		1,243,591	(120,054)	1,123,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			27,392	27,392		27,392		27,392			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			443,583	443,583		443,583		443,583			42
43	Other (specify):* See Attached			2,205	2,205		2,205	(2,205)				43
44	TOTAL Special Cost Centers			473,180	473,180		473,180	(2,205)	470,975			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,346,783	546,226	5,887,765	9,780,774		9,780,774	(615,076)	9,165,698			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2011

Schedule 4a

E. Special Cost Centers		Operating	Adjusted Total
Line 43	Other (Specify):		
	Non Allowable Contributions	565	-
	Non-allowable Meals & Entertainment	1,640	-
		2,205	-

See Accountants' Compilation Report

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	43,980	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	(2,948)	32		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	(1,640)	43		19
20	Contributions	(565)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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 PG5 A	(568,566)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (529,739)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(85,337)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (85,337)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (615,076)		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

SEE ACCOUNTANTS' COMPILATION REPORT

ID#042614

Report Period Beginning:1/1/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Management Fees	\$ (384,387)	17	1
2	Dues and Subscriptions	(15,407)	20	2
3	Rental Expense	(5,005)	35	3
4	Capitalized Maintenance	(163,767)	6	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				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	(568,566)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center, Inc. # 042614 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	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	(163,767)	0	0	0	0	0	0	0	0	0	0	(163,767)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(163,767)	0	0	0	0	0	0	0	0	0	0	(163,767)	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	(384,387)	0	0	0	0	0	0	0	0	0	0	(384,387)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,775	0	0	0	0	0	0	0	0	0	27,775	19
20	Fees, Subscriptions & Promotions	(15,407)	0	0	0	0	0	0	0	0	0	0	(15,407)	20
21	Clerical & General Office Expenses	0	25	0	0	0	0	0	0	0	0	0	25	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	42,944	0	0	0	0	0	0	0	0	0	42,944	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(399,794)	70,744	0	0	0	0	0	0	0	0	0	(329,050)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(563,561)	70,744	0	0	0	0	0	0	0	0	0	(492,817)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center, Inc. # 042614 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	43,980	230,594	0	0	0	0	0	0	0	0	0	274,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,948)	483,474	0	0	0	0	0	0	0	0	0	480,526	32
33	Real Estate Taxes	0	315,946	0	0	0	0	0	0	0	0	0	315,946	33
34	Rent-Facility & Grounds	0	(1,186,095)	0	0	0	0	0	0	0	0	0	(1,186,095)	34
35	Rent-Equipment & Vehicles	(5,005)	0	0	0	0	0	0	0	0	0	0	(5,005)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	36,027	(156,081)	0	0	0	0	0	0	0	0	0	(120,054)	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):*	(2,205)	0	0	0	0	0	0	0	0	0	0	(2,205)	43
44	TOTAL Special Cost Centers	(2,205)	0	0	0	0	0	0	0	0	0	0	(2,205)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(529,739)	(85,337)	0	0	0	0	0	0	0	0	0	(615,076)	45

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
Anthony Miner	100			Golfview Realty	Chicago	Real Estate
				Partnership d/b/a		
				Golfview Partnership		
				Venture		

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	\$	Golfview Realty Partnership	100.00%	\$ 42,944	\$ 42,944	1
2	V	30	Depreciation		Golfview Realty Partnership	100.00%	230,594	230,594	2
3	V	32	Interest Expense		Golfview Realty Partnership	100.00%	484,250	484,250	3
4	V	33	Real Estate Taxes		Golfview Realty Partnership	100.00%	315,946	315,946	4
5	V	34	Rent Expense	1,186,095	Golfview Realty Partnership	100.00%		(1,186,095)	5
6	V	19	Professional Fees		Golfview Realty Partnership	100.00%	27,775	27,775	6
7	V	21	Bank Charges		Golfview Realty Partnership	100.00%	25	25	7
8	V	32	Interest Income		Golfview Realty Partnership	100.00%	(776)	(776)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,186,095			\$ 1,100,758	\$ * (85,337)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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	Anthony Minerr	President	Administrator	100.00	None	70-80	100.00	Salary	\$ 94,950	17,1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 94,950		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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center, Inc. # 042614 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Midland Loan Services, Inc.		x	Mortgage	\$48,209.00	4/17/03	\$ 9,225,000	\$ 8,544,725	5/31/2043	5.6000	\$ 481,020	1
2	Midland Loan Services, Inc.		x	Mortgage Costs							3,230	2
3	Interest Income Offset		x								(68,662)	3
4	Shareholder Loan	x		Working Capital	Interest Only	Various	808,857	808,857			4,540	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$48,209.00		\$ 10,033,857	\$ 9,353,582			\$ 420,128	9
	B. Non-Facility Related*											
10	Shareholder Loan	x		Working Capital - Excess interest over Prime paid to related party							(2,948)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (2,948)	14
15	TOTALS (line 9+line14)						\$ 10,033,857	\$ 9,353,582			\$ 417,180	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 42,994 Line # 26

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

HFS 3745 (N-4-99)

IL478-2471

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 2010 report.		\$	136,964		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.)		\$	305,698		2
3. Under or (over) accrual (line 2 minus line 1).		\$	168,734		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	147,212		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.		\$	315,946		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	262,006	8		
	2007	257,103	9		
	2008	268,580	10		
	2009	273,927	11		
	2010	294,425	12		
2010 Tax Assessment 294,425					
5% Increase x 1.05					
2011 Estimated Taxes 309,146					
Use 147,212 (309,146 less 161,934 paid 12/31/11)					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Center, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 042614

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847)827-6628 FAX #: (847)727-0948

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>09-15-100-012-0000</u>	<u>9555 Golf Road, Des Plaines, IL 6001</u>	\$ <u>27,109.61</u>	\$ <u>27,109.61</u>
2.	<u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL 6001</u>	\$ <u>267,315.32</u>	\$ <u>267,315.32</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>294,424.93</u></u>	\$ <u><u>294,424.93</u></u>

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 x _____ 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

None

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: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Residential Care	117,000	1977	\$ 234,000	1
2					2
3	TOTALS	117,000		\$ 234,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	128		1997	1977	\$ 8,641,370	\$	40	\$ 216,034	\$ 216,034	\$ 3,042,532	4
5			1997		(580,616)		39	(14,887)	(14,887)	(201,749)	5
6			1998		40,292		40	1,007	1,007	13,596	6
7	7		1999	1999	52,495		40	1,312	1,312	16,401	7
8											8
	Improvement Type**										
9	Fencing			1997	1,200		10			1,200	9
10	Lobby Notice Board			1998	3,380		15			3,380	10
11	Parking Lot			1998	139,900		15	9,327	9,327	125,913	11
12	Exhaust System			1999	2,801		10			2,707	12
13	Compressor			1999	11,972		10			11,971	13
14	Fencing			1999	1,800		10			1,800	14
15	Fire Vents			1999	1,806		10			1,808	15
16	Elevator			1999	932		10			931	16
17	Security System			1999	970		10			970	17
18	Heating Unit			2000	715		10			694	18
19	Security System			2000	2,017		10			1,968	19
20	Telephone Line			2000	7,234		10			7,232	20
21	Security System			2000	2,087		10			2,085	21
22	Specialty Wiring & Oxygen Lines			2001	567,060		10			567,060	22
23	Security System			2001	4,803	241	10	241		4,803	23
24	Security System			2001	17,731	887	10	887		17,731	24
25	Fire Alarm Systems			2001	7,583	380	10	380		7,583	25
26	Security System			2002	4,402	440	10	440		4,181	26
27	Hot Water Tanks			2002	3,142	314	10	314		2,984	27
28	Hot Water Pipes			2003	9,150	915	10	915		7,930	28
29	Tile and Wall Coverings			2003	4,190	419	10	419		3,492	29
30	Door			2003	3,624	362	10	362		3,019	30
31	Resident Room Repair			2003	5,314	532	10	532		4,250	31
32	2 New Faucets			2003	2,308	230	10	230		1,846	32
33	Floor Repair & Replace			2004	5,966	596	10	596		4,673	33
34	Drywall			2004	6,749	675	10	675		5,287	34
35	Remove Sound Walls			2004	15,133	1,513	10	1,513		11,098	35
36	Dishwasher			2004	2,850	285	10	285		2,114	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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
37	Piping Repairs	2004	\$ 3,458	\$ 346	10	\$ 346	\$	\$ 2,478	37
38	Entry System	2005	3,700	370	10	370		2,590	38
39	Fire Damper Access Patch	2005	20,122	2,012	10	2,012		12,743	39
40	Floor Repair and Replace	2005	2,290	229	10	229		1,394	40
41	Stairwell Construction Repair	2006	120,795	12,079	10	12,079		70,464	41
42	Kitchen Improvements	2006	12,735	1,274	10	1,274		7,321	42
43	New Dock Door	2006	5,982	598	10	598		3,439	43
44	Kitchen Improvements	2006	6,000	600	10	600		3,100	44
45	Gauges	2006	2,768	277	10	277		1,523	45
46	Kitchen Improvements	2006	5,320	532	10	532		2,847	46
47	Interior Painting	2007	17,755		5	3,551	3,551	16,571	47
48	Kitchen Improvements	2007	18,996	1,899	10	1,899		8,243	48
49	New Door Installation	2007	30,313	3,031	10	3,031		14,397	49
50	New Fencing	2007	8,076	807	10	807		3,382	50
51	Interior Painting	2008	77,681		9	8,631	8,631	30,209	51
52	Elevator Pump Repairs	2008	11,875		9	1,319	1,319	4,617	52
53	Ceiling Valves	2008	2,130	213	9	213		639	53
54	Painting	2009	57,865		8	7,233	7,233	18,083	54
55	Parking Lot	2009	12,183		8	1,523	1,523	3,934	55
56	Lobby Repairs	2009	12,485		8	1,561	1,561	4,032	56
57	Bathroom Repairs	2009	42,802		8	5,350	5,350	11,592	57
58	Door Repairs	2009	3,438		8	430	430	860	58
59	Freezer Repairs	2009	8,666		8	1,083	1,083	2,437	59
60	Fire Pump	2009	6,496		8	812	812	2,098	60
61	Fuses	2009	2,772	277	10	277		785	61
62	Door Hinges	2009	6,408	642	10	642		1,390	62
63	Boiler	2009	4,300	430	10	430		896	63
64	FRP Installation	2010	3,821		7	546	546	591	64
65	Floor & Ceiling Tile Repairs	2010	8,306		7	1,187	1,187	1,286	65
66	Roof Repairs	2010	3,085		7	441	441	478	66
67	Repair/Replace Sinks & Pipes	2010	16,822		7	2,403	2,403	3,004	67
68	Repair Refrigerator	2010	3,224		7	461	461	615	68
69	Door Repairs	2010	3,367		7	481	481	922	69
70	TOTAL (lines 4 thru 69)		\$ 9,536,396	\$ 33,405		\$ 283,210	\$ 249,805	\$ 3,920,450	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,536,396	\$ 33,405		\$ 283,210	\$ 249,805	\$ 3,920,450	1
2	Radiator	2010	3,896		7	557	557	928	2
3	Sidewalk fire Pump	2010	5,508		15	367	367	581	3
4	Fire Pump	2010	3,463		7	495	495	825	4
5	Carpeting	2010	5,370	537	10	537		761	5
6	Replace Bathroom Stalls	2010	10,633	1,063	10	1,063		1,506	6
7	Keycard System	2010	9,065	3,022	3	3,022		4,029	7
8	Water Heater	2011	33,995		6	3,305	3,305	3,305	8
9	New Lighting Fixtures	2011	25,294		6	351	351	351	9
10	FRP Installation & Painting	2011	54,329		6	6,037	6,037	6,037	10
11	Roof Repairs	2011	36,623		6	1,017	1,017	1,017	11
12	Bathroom Stalls & Tiling	2011	41,224		6	3,435	3,435	3,435	12
13	Exterior Painting	2011	11,023		6	306	306	306	13
14	Dining Room Painting	2011	7,176		6	99	99	99	14
15	Kitchen Vacuum	2011	4,487	337	7	337		337	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)		\$ 9,788,482	\$ 38,364		\$ 304,138	\$ 265,774	\$ 3,943,967	34

SEE ACCOUNTANTS' COMPILATION REPORT

****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	\$ 1,042,442	\$ 19,797	\$ 21,156	\$ 1,359	5-10 years	\$ 969,757	71
72	Current Year Purchases	85,029	12	7,453	7,441	5-10 years	7,453	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,127,471	\$ 19,809	\$ 28,609	\$ 8,800		\$ 977,210	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	2
		Reference	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)	\$ 11,149,953	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,173	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 332,747	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 274,574	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,921,177	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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:
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:
- *

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: \$ 7,005
- Description: Postage Meter \$690; Copier \$5,237; Ice Maker \$1,078
- (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	Resident Transport	2009 Ford	\$ 895.00	\$ 10,740	17
18	Resident Transport	2009 Ford	795.00	5,565	18
19	Resident Transport	2011 Ford	899.00	10,788	19
20	See Attached 14a		#####	23,566	20
21	TOTAL		\$ #####	\$ 50,659	21

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. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.

Schedule 14a

Page 14 - Vehicle Rental

<u>Use</u>	<u>Model Year & Make</u>	<u>Monthly Lease Payment</u>	<u>Rental Expense for this period</u>
Administrative	2009 Acura	579.00	1,737
Administrative	2011 Acura	549.00	4,941
Resident Transport	2011 Ford E354	895.00	5,370
Resident Transport	2011 Ford E354	899.00	10,788
Acura Lease Initiation Fee			730
		<u>2,922.00</u>	<u>23,566.00</u>

See Accountants' Compilation Report

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

☐ 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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

90

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	375	900		1,275
3	Classroom Wages (a)	3,721	11,880		15,601
4	Clinical Wages (b)	4,469	26,730		31,199
5	In-House Trainer Wages (c)	11,865	29,050		40,915
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 20,430	\$ 68,560	\$	\$ 88,990
10	SUM OF line 9, col. 1 and 2 (e)	\$ 88,990			

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	36
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	15
2. From other facilities (f)	
TOTAL TRAINED	51

(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.

SEE ACCOUNTANTS' COMPILATION REPORT

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L39, C2	visits				27,392		27,392	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 27,392		\$ 27,392	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 73,002	\$ 220,636	1
2	Cash-Patient Deposits	105,753	105,753	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,346,635	4,346,635	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(9,058)	8,752	6
7	Other Prepaid Expenses	43,309	43,309	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached Schedule 17a</u>		25,003	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,559,641	\$ 4,750,088	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		234,000	13
14	Buildings, at Historical Cost		9,047,981	14
15	Leasehold Improvements, at Historical Cost	386,593	701,470	15
16	Equipment, at Historical Cost	243,969	1,127,472	16
17	Accumulated Depreciation (book methods)	(411,132)	(4,811,553)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See attached Schedule 17a</u>		536,830	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 219,430	\$ 6,836,200	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,779,071	\$ 11,586,288	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,336,943	\$ 1,336,943	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	105,753	105,753	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	337,394	337,394	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		147,212	32
33	Accrued Interest Payable	1,766	1,766	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17a</u>	5,556,290	4,810,563	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,338,146	\$ 6,739,631	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,544,725	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,544,725	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,338,146	\$ 15,284,356	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,559,075)	\$ (3,698,068)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,779,071	\$ 11,586,288	48

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2011

Schedule 17a

Page 17 - Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other Current Assets		
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	<u>-</u>	<u>25,003</u>
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	435,761
Mortgage Costs, net	-	101,069
	<u>-</u>	<u>536,830</u>
Line 36 - Other Current Liabilities		
Due to Shareholders	808,857	808,857
Provider Participation Fees Payable	4,925	4,925
Due to 3rd-Party Payor	452,297	452,297
Accrued Management Fees	3,544,484	3,544,484
Due to Affiliates	745,727	-
	<u>5,556,290</u>	<u>4,810,563</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,861,254)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,861,254)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	302,179	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)	\$ 302,179	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)	\$ (2,559,075)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center, Inc.# 042614Report Period Beginning: 1/1/11Ending: 12/31/11

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,853,365	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,853,365	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	59,317	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		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,317	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Early Discharge	102,928	28
28a	Miscellaneous Income See Attached Pg 19A	67,343	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 170,271	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,082,953	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,556,060	31
32	Health Care	2,529,149	32
33	General Administration	1,978,794	33
	B. Capital Expense		
34	Ownership	1,243,591	34
	C. Ancillary Expense		
35	Special Cost Centers	29,597	35
36	Provider Participation Fee	443,583	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,780,774	40
41	Income before Income Taxes (line 30 minus line 40)**	302,179	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 302,179	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2011

Schedule 19a

Page 19 - Income Statement	<u>Operating</u>	<u>After Consolidation</u>
Line 28a - Miscellaneous Income		
Flu Vaccines	2,655	2,655
Miscellaneous Income	52,737	710
Vending Machines	1,369	1,369
Commissary Income	10,582	10,582
	-	
	<u>67,343</u>	<u>15,316</u>

See Accountants' Compilation Report

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,821	2,086	\$ 68,326	\$ 32.75	1
2	Assistant Director of Nursing	1,996	2,054	52,669	25.64	2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,963	14,221	358,991	25.24	4
5	CNAs & Orderlies	1,935	2,110	19,490	9.24	5
6	CNA Trainees	5,573	5,573	45,977	8.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,733	2,086	28,454	13.64	9
10	Activity Assistants	5,872	6,466	64,266	9.94	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,826	2,086	57,176	27.41	14
15	Cook Helpers/Assistants	19,914	21,550	196,474	9.12	15
16	Dishwashers					16
17	Maintenance Workers	3,659	3,996	56,662	14.18	17
18	Housekeepers	25,639	27,777	304,263	10.95	18
19	Laundry	1,793	2,099	29,150	13.89	19
20	Administrator	1,677	2,086	79,843	38.28	20
21	Assistant Administrator					21
22	Other Administrative	2,083	2,268	34,457	15.19	22
23	Office Manager	1,849	2,086	50,193	24.06	23
24	Clerical	2,860	3,067	30,117	9.82	24
25	Vocational Instruction					25
26	Academic Instruction	1,839	2,126	40,248	18.93	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,357	14,234	222,603	15.64	28
29	Resident Services Coordinator	1,980	2,086	47,683	22.86	29
30	Habilitation Aides (DD Homes)	147,628	157,097	1,464,791	9.32	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Exec. Director</u>	1,704	2,086	94,950	45.52	33
34	TOTAL (lines 1 - 33)	259,701	279,240	\$ 3,346,783 *	\$ 11.99	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	171	\$ 8,887	L1, C3	35
36	Medical Director	96	16,391	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,240	L10, C3	39
40	Physical Therapy Consultant	29	1,813	L10A, C3	40
41	Occupational Therapy Consultant	6	391	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,250	L10A, C3	43
44	Activity Consultant	39	2,418	L11, C3	44
45	Social Service Consultant	168	11,609	L12, C3	45
46	Other(specify) <u>Psychologist</u>	22	3,500	L10, C3	46
47	<u>Psychiatrist</u>	44	2,200	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	643	\$ 51,699		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Anthony Miner	Administrator	100	\$ 94,950	Workers' Compensation Insurance	\$ 68,261		IDPH License Fee	\$
Barbara Water	Asst. Administrator	0	79,843	Unemployment Compensation Insurance	33,646		Advertising: Employee Recruitment	16,648
				FICA Taxes	246,333		Health Care Worker Background Check	1,593
				Employee Health Insurance	155,146		(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Health Care Association	2,320
				Union Health & Welfare	133,844		Cook County	1,218
				Other Employee Benefits	86,759		Illinois Secretary of State	2,460
TOTAL (agree to Schedule V, line 17, col. 1)							Collaborative Healthcare Urgency Group	500
(List each licensed administrator separately.)							Miscellaneous Licenses & Fees	4,893
							Less: Public Relations Expense	()
B. Administrative - Other							Non-allowable advertising	()
Description			Amount				Yellow page advertising	()
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$ 723,989		TOTAL (agree to Sch. V,	\$ 29,632
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Deutsch, Levy & Engel, Chartered	Legal Fees		\$ 47,270			\$	Out-of-State Travel	\$
Edwards & Wildmna	Legal Fees		2,840					
Margel Peddicord	Consulting Fees		650					
Personnel Planners	Consulting Fees		4,416				In-State Travel	
Polsinelli & Shuggart	Legal Fees		56,893					
Shaw Gussis Fishman Glantz	Legal Fees		4,966					
Warady & Davis LLP	Accounting Fees		13,009					
WD Consulting	Consulting Fees		4,250				Seminar Expense	6,690
Wildman, Harrold, Allen & Dixon	Legal Fees		44,054					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$ 6,690
			\$ 178,348					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$2,320

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(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? 5-10yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,803 Line 10

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 443,583 paid & accrued
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 53,723 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. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes, except owner's vehicle
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 23a

Page 23 - General Information

Line 12 - Allocation Explanation

Santosha Welch	Works in Activities, works OT as an Aide
Mitzie Langford	Works in Medical Records, works OT as an Aide
Elayne Rayner	Works in Activities, works OT as an Aide
Jayapal Pillai	Works in Activities, works OT as an Aide
Zachary Karner	Split time between Activities and Aide
Siji Koshy	Split time between Activities and Aide
Tyanna Mingo	Split time between QMRP and Aide
Tierra Howleit	Split time between Dietary and Aide
Jonathon Sullivan	Split time between Dietary and Aide
Lois Davis	Split time between Dietary and Aide
Jessica Anderson	Split time between Activities and Aide
Stephen Riordan	Split time between Dietary and Aide
Nicholas Ramos Gonzales	Split time between Dietary and Aide

See Accountants' Compilation Report