

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0042614</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Golfview Developmental Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.	
Address: <u>9555 West Golf Road</u> <u>Des Plaines</u> <u>60016</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(847)827-6628</u> Fax # <u>(847)827-0948</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>11/17/97</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	135	Intermediate (ICF)	135	49,410	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,410	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	48,129			48,129	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,129			48,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.41%

D. How many bed-hold days during this year were paid by the Department? 574 (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	247,088	41,683	8,911	297,682		297,682		297,682		1
2	Food Purchase		272,057		272,057		272,057		272,057		2
3	Housekeeping	311,243	59,526		370,769		370,769		370,769		3
4	Laundry	29,161	7,472		36,633		36,633		36,633		4
5	Heat and Other Utilities			231,751	231,751		231,751		231,751		5
6	Maintenance	53,672	30,374	130,906	214,952		214,952	(8,731)	206,221		6
7	Other (specify):* Workshop Expense			1,982,865	1,982,865		1,982,865		1,982,865		7
8	TOTAL General Services	641,164	411,112	2,354,433	3,406,709		3,406,709	(8,731)	3,397,978		8
	B. Health Care and Programs										
9	Medical Director			16,392	16,392		16,392		16,392		9
10	Nursing and Medical Records	2,213,317	57,768	15,375	2,286,460		2,286,460		2,286,460		10
10a	Therapy			704	704		704		704		10a
11	Activities	96,990	12,680	1,512	111,182		111,182		111,182		11
12	Social Services			13,580	13,580		13,580		13,580		12
13	CNA Training	88,615			88,615		88,615		88,615		13
14	Program Transportation					30,266	30,266		30,266		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,398,922	70,448	47,563	2,516,933	30,266	2,547,199		2,547,199		16
	C. General Administration										
17	Administrative	180,708		548,396	729,104		729,104	(548,396)	180,708		17
18	Directors Fees										18
19	Professional Services			112,488	112,488		112,488	52,356	164,844		19
20	Dues, Fees, Subscriptions & Promotions			29,523	29,523		29,523	(5,521)	24,002		20
21	Clerical & General Office Expenses	116,242	41,104	144,820	302,166		302,166	494	302,660		21
22	Employee Benefits & Payroll Taxes			872,575	872,575		872,575		872,575		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,368	10,368		10,368		10,368		24
25	Other Admin. Staff Transportation			40,355	40,355	(30,266)	10,089		10,089		25
26	Insurance-Prop.Liab.Malpractice			92,825	92,825		92,825	46,712	139,537		26
27	Other (specify):*										27
28	TOTAL General Administration	296,950	41,104	1,851,350	2,189,404	(30,266)	2,159,138	(454,355)	1,704,783		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,337,036	522,664	4,253,346	8,113,046		8,113,046	(463,086)	7,649,960		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			55,870	55,870		55,870	299,382	355,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,952	74,952		74,952	568,691	643,643			32
33	Real Estate Taxes							302,660	302,660			33
34	Rent-Facility & Grounds			1,267,700	1,267,700		1,267,700	(1,267,700)				34
35	Rent-Equipment & Vehicles			62,153	62,153		62,153	(5,195)	56,958			35
36	Other (specify):*											36
37	TOTAL Ownership			1,460,675	1,460,675		1,460,675	(102,162)	1,358,513			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			27,659	27,659		27,659		27,659			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			471,477	471,477		471,477		471,477			42
43	Other (specify):* Travel & Entertainment			2,827	2,827		2,827	(2,827)				43
44	TOTAL Special Cost Centers			501,963	501,963		501,963	(2,827)	499,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,337,036	522,664	6,215,984	10,075,684		10,075,684	(568,075)	9,507,609			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

		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				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	63,064	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	(19,703)	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	(2,827)	43		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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(542,354)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (501,820)		\$	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)	(66,255)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,255)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (568,075)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Golfview Developmental Center

Report Period Beginning: ID# 0042614

Ending: 1/1/12

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Management Fees	\$ (548,396)	17	1
2	Dues and Subscriptions	(5,521)	20	2
3	Auto Leasing	(5,195)	35	3
4	Capitalized Maintenance	(8,731)	6	4
5	Professional Fees	33,986	19	5
6	Loan Costs	(8,497)	32	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	(542,354)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(8,731)	0	0	0	0	0	0	0	0	0	0	(8,731)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,731)	0	0	0	0	0	0	0	0	0	0	(8,731)	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	(548,396)	0	0	0	0	0	0	0	0	0	0	(548,396)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	33,986	18,370	0	0	0	0	0	0	0	0	0	52,356	19
20	Fees, Subscriptions & Promotions	(5,521)	0	0	0	0	0	0	0	0	0	0	(5,521)	20
21	Clerical & General Office Expenses	0	494	0	0	0	0	0	0	0	0	0	494	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	46,712	0	0	0	0	0	0	0	0	0	46,712	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(519,931)	65,576	0	0	0	0	0	0	0	0	0	(454,355)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(528,662)	65,576	0	0	0	0	0	0	0	0	0	(463,086)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	63,064	236,318	0	0	0	0	0	0	0	0	0	299,382	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,200)	596,891	0	0	0	0	0	0	0	0	0	568,691	32
33	Real Estate Taxes	0	302,660	0	0	0	0	0	0	0	0	0	302,660	33
34	Rent-Facility & Grounds	0	(1,267,700)	0	0	0	0	0	0	0	0	0	(1,267,700)	34
35	Rent-Equipment & Vehicles	(5,195)	0	0	0	0	0	0	0	0	0	0	(5,195)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	29,669	(131,831)	0	0	0	0	0	0	0	0	0	(102,162)	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):*	(2,827)	0	0	0	0	0	0	0	0	0	0	(2,827)	43
44	TOTAL Special Cost Centers	(2,827)	0	0	0	0	0	0	0	0	0	0	(2,827)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(501,820)	(66,255)	0	0	0	0	0	0	0	0	0	(568,075)	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	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	\$	Golfview Realty Partnership	100.00%	\$ 46,712	\$ 46,712	1
2	V	30	Depreciation		Golfview Realty Partnership	100.00%	236,318	236,318	2
3	V	32	Interest Expense		Golfview Realty Partnership	100.00%	601,495	601,495	3
4	V	33	Real Estate Taxes		Golfview Realty Partnership	100.00%	302,660	302,660	4
5	V	34	Rent Expense	1,267,700	Golfview Realty Partnership	100.00%		(1,267,700)	5
6	V	19	Professional Fees		Golfview Realty Partnership	100.00%	18,370	18,370	6
7	V	21	Bank Charges		Golfview Realty Partnership	100.00%	494	494	7
8	V	32	Interest Income		Golfview Realty Partnership	100.00%	(4,604)	(4,604)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,267,700			\$ 1,201,445	\$ * (66,255)	14

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

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 Miner	President	Administrator	100.00	None	70-80	100.00	Salary	\$ 96,579	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	\$ 96,579		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 # 0042614 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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	Shareholder Loan	x		Working Capital	Interest Only	Various	\$ 808,857	\$			\$ 32,554	1	
2	Wintrust		x	Working Capial	Interest Only	Various	823,000	823,000		5.0000	3,882	2	
3	PR Mortgage and Inv		x	Mortgage	\$33,863.91	10/1/12	8,740,000	8,707,928	5/31/2034	2.4500	53,255	3	
4	Midland Loan Services		x	Mortgage	\$48,209.00	4/17/03	9,225,000			5.6000	361,269	4	
5	See Attached		x								212,206	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$82,072.91		\$ 19,596,857	\$ 9,530,928			\$ 663,166	9	
	B. Non-Facility Related*												
10	Shareholder Loan	x		Working Capital - Excess Interest over Prime paid to related party							(19,703)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (19,703)	14	
15	TOTALS (line 9+line14)						\$ 19,596,857	\$ 9,530,928			\$ 643,463	15	

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

* 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.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2012

Schedule 9a

Page 9 Interest Expense and Real Estate Tax Expense

<u>Name of Lender</u>	<u>Related</u>		<u>Purpose of Loan</u>	<u>Monthly Payment Required</u>	<u>Date of Note</u>	<u>Amount of Note</u>		<u>Maturity Date</u>	<u>Interest Rate</u>	<u>Reporting Period</u>
	<u>Yes</u>	<u>No</u>				<u>Original</u>	<u>Balance</u>			<u>Interest Expense</u>
Midland Loan Servcies	x		Mortgage Cost - Prepayment							84,683
Interest income Offsett	x									(16,467)
State of Illinois	x		Pre-Bankruptcy DPA Fees							41,882
Midland Loan Services	x		Mortgage Costs							102,108

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 2011 report.				\$	147,212	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.)				\$	300,651	2
3. Under or (over) accrual (line 2 minus line 1).				\$	153,439	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	149,221	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.				\$	302,660	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2007	257,103	8		
		2008	268,580	9		
		2009	273,927	10		
		2010	294,425	11		
		2011	298,442	12		

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Golfview Developmental Center</u>	COUNTY	<u>Cook</u>
---------------	--------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0042614

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 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 09-15-100-013-0000	9555 Golf Road, Des Plaines, IL 6001	\$ 270,962.33	\$
2. 09-15-100-012-0000	9555 Golf Road, Des Plaines, IL 6001	\$ 27,479.40	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 298,441.73	\$

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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

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	\$ 1,126,745	\$ 19,277	\$ 32,677	\$ 13,400	5-10 years	\$ 1,009,890	71
72	Current Year Purchases	11,236		746	746	5-15 years	746	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,137,981	\$ 19,277	\$ 33,423	\$ 14,146		\$ 1,010,636	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)	\$ 11,196,614	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,870	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 355,252	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 299,382	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,276,431	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		\$	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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: \$ 6,965
- Description: Ice maker \$1176; Copier \$5237; Postage Meter; 552
- (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	2011 Ford	899.00	10,788	18
19	Resident Transport	2011 Ford	895.00	10,740	19
20	See Attached		#####	17,725	20
21	TOTAL		\$ #####	\$ 49,993	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2012

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	2011 Acura	549.00	6,588
Resident Transport	2011 Ford E354	899.00	10,788
Resident Transport	2011 Ford Daily Rental		349
		<u>1,448.00</u>	<u>17,725.00</u>

See Accountants' Compilation Report

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	350	950		1,300
3	Classroom Wages (a)	3,422	12,540		15,962
4	Clinical Wages (b)	1,029	28,215		29,244
5	In-House Trainer Wages (c)	13,594	28,515		42,109
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 18,395	\$ 70,220	\$	\$ 88,615
10	SUM OF line 9, col. 1 and 2 (e)	\$ 88,615			

(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.

D. NUMBER OF CNAs TRAINED

SEE ACCOUNTANTS' COMPILATION REPORT

COMPLETED	
1. From this facility	38
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	14
2. From other facilities (f)	
TOTAL TRAINED	52

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, C3	visits				27,659		27,659	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):									12
13	Other (specify):									13
14	TOTAL			\$		\$	27,659		\$ 27,659	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 552,334	\$ 819,750	1
2	Cash-Patient Deposits	94,760	94,760	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,048,537	3,048,537	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,795	53,570	6
7	Other Prepaid Expenses	49,112	49,112	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17a		68,848	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,765,538	\$ 4,134,577	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		9,075,402	14
15	Leasehold Improvements, at Historical Cost	386,593	710,201	15
16	Equipment, at Historical Cost	243,969	1,137,982	16
17	Accumulated Depreciation (book methods)	(467,002)	(5,103,741)	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): See Attached Schedule 17a	25,489	526,255	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 189,049	\$ 6,580,099	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,954,587	\$ 10,714,676	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 658,987	\$ 658,987	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,760	94,760	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	367,445	367,445	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		149,221	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17a	5,470,867	4,714,557	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,592,059	\$ 5,984,970	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,707,928	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)	\$	\$ 8,707,928	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,592,059	\$ 14,692,898	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,637,472)	\$ (3,978,222)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,954,587	\$ 10,714,676	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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>68,848</u>
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required		
for Replacement Reserves	-	400,193
Mortgage Costs, net	<u>25,489</u>	<u>126,062</u>
	<u>25,489</u>	<u>526,255</u>
Line 36 - Other Current Liabilities		
LOC Payable	823,000	823,000
Provider Participation Fees Payable	206,534	206,534
Due to 3rd-Party Payor	246,393	246,393
Accrued Management Fees	3,438,630	3,438,630
Due to Affiliates	<u>756,310</u>	<u>-</u>
	<u>5,470,867</u>	<u>4,714,557</u>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,559,075)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,559,075)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(78,397)	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)	\$ (78,397)	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)	\$ (2,637,472)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,871,247	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,871,247	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	88,015	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)	\$ 88,015	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	36,754	28
28a	Miscellaneous Income. See Attached Pg 19A	1,271	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38,025	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,997,287	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,406,709	31
32	Health Care	2,516,933	32
33	General Administration	2,189,404	33
	B. Capital Expense		
34	Ownership	1,460,675	34
	C. Ancillary Expense		
35	Special Cost Centers	30,486	35
36	Provider Participation Fee	471,477	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,075,684	40
41	Income before Income Taxes (line 30 minus line 40)**	(78,397)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (78,397)	43
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,888,382	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Routine Service - Workshop	1,982,865	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,871,247	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 19a

Page 19 - Income Statement	<u>Operating</u>	<u>After Consolidation</u>
Line 28a - Miscellaneous Income		
Miscellaneous Income	99	99
Vending Machines	1,172	1,172
	<u>1,271</u>	<u>1,271</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	1,775	2,091	\$ 66,945	\$ 32.02	1
2	Assistant Director of Nursing	1,568	1,753	46,558	26.56	2
3	Registered Nurses					3
4	Licensed Practical Nurses	13,344	14,544	367,850	25.29	4
5	CNAs & Orderlies	1,961	2,138	20,137	9.42	5
6	CNA Trainees	5,831	5,831	48,216	8.27	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,834	2,091	30,495	14.58	9
10	Activity Assistants	6,575	7,379	66,495	9.01	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,878	2,091	50,614	24.21	14
15	Cook Helpers/Assistants	20,278	21,723	196,474	9.04	15
16	Dishwashers					16
17	Maintenance Workers	3,545	3,974	53,672	13.51	17
18	Housekeepers	25,572	28,628	311,243	10.87	18
19	Laundry	1,803	2,102	29,161	13.87	19
20	Administrator	1,802	2,091	84,129	40.23	20
21	Assistant Administrator					21
22	Other Administrative	1,929	2,227	32,034	14.38	22
23	Office Manager	1,873	2,091	51,579	24.67	23
24	Clerical	2,984	3,267	32,629	9.99	24
25	Vocational Instruction					25
26	Academic Instruction	1,863	2,091	40,399	19.32	26
27	Medical Director	1,766	2,091	96,579	46.19	27
28	Qualified MR Prof. (QMRP)	13,452	14,625	225,957	15.45	28
29	Resident Services Coordinator	1,905	2,091	46,353	22.17	29
30	Habilitation Aides (DD Homes)	150,029	161,188	1,439,517	8.93	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,567	286,107	\$ 3,337,036 *	\$ 11.66	34

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	174	\$ 8,911	L1, C3	35
36	Medical Director	48	16,392	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	9	547	L10A, C3	40
41	Occupational Therapy Consultant	1	63	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	94	L10A, C3	43
44	Activity Consultant	24	1,512	L11, C3	44
45	Social Service Consultant	194	13,580	L12, C3	45
46	Other(specify) <u>Psychologist</u>	16	9,735	L10, C3	46
47	<u>Psychiatrist</u>	48	2,400	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	564	\$ 56,474		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Golfview Developmental Center

0042614Report Period Beginning: 1/1/12Page 21Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	100	\$ 96,579
Barbara Water	Assistant Administrator	0	84,129
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 180,708

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Edwards Wildman	Legal	\$ 11,672
Holland & Knight	Legal	3,291
Personnel Planners	Human Resources	4,861
Polsinelli Shugart	Legal	78,664
Urban Real Estate Research	Real Estate Appraisal	2,500
Warady & Davis	Accounting	11,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 112,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 74,073
Unemployment Compensation Insurance	55,843
FICA Taxes	248,638
Employee Health Insurance	201,501
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	135,870
Other Employee Benefits	156,650
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	12,815
Health Care Worker Background Check (Indicate # of checks performed)	1,987
Patient Background Checks	
Illinois Health Care Association	2,207
Cook County	1,361
Illinois Secretary of State	690
ID Card Software	598
Miscellaneous Licences and fees	4,344
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	10,368
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 10,368

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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.

IL Healthcare Association \$2,207
- (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?

5-10 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 7,782

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.

\$ 471,477

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

Yes

If YES, attach an explanation of the allocation.

- (13)

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

yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 61,151

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

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 owners 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?

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?

No

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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