

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0042614</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Golfview Developmental Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</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>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 827-6628</u> Fax # <u>(847)-827-0948</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Warady & Davis LLP</u> <u>1717 Deerfield Road, Ste 300 South, Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847)267-9600</u> Fax # <u>(847)267-9696</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Warady & Davis LLP</u> <u>1717 Deerfield Road, Ste 300 South, Deerfield, IL 60015</u>	(Telephone) <u>(847)267-9600</u> Fax # <u>(847)267-9696</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) <u>Warady & Davis LLP</u> <u>1717 Deerfield Road, Ste 300 South, Deerfield, IL 60015</u>																								
	(Telephone) <u>(847)267-9600</u> Fax # <u>(847)267-9696</u>																								
Date of Initial License for Current Owners: <u>11/17/97</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ 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 _____	
☐ 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:		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																							
Name: <u>Rocco Losch</u> Telephone Number: <u>847-267-9600</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Developmental Ctr

0042614 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	44,122			44,122	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,122			44,122	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.30 %

D. How many bed reserve days during this year were paid by the Department? 772 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/20 Ending: 12/31/20
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	249,433	63,990	168,066	481,489		481,489		481,489			1
2	Food Purchase		311,844		311,844		311,844		311,844			2
3	Housekeeping	422,921	57,666		480,587		480,587		480,587			3
4	Laundry	48,741	11,171		59,912		59,912		59,912			4
5	Heat and Other Utilities			190,376	190,376		190,376		190,376			5
6	Maintenance	42,153	34,008	62,351	138,512		138,512		138,512			6
7	Other (specify):*			1,525,372	1,525,372		1,525,372		1,525,372			7
8	TOTAL General Services	763,248	478,679	1,946,165	3,188,092		3,188,092		3,188,092			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,237,625	249,629	1,381,423	3,868,677		3,868,677		3,868,677			10
10a	Therapy											10a
11	Activities	124,057	4,701	630	129,388		129,388		129,388			11
12	Social Services			14,560	14,560		14,560		14,560			12
13	CNA Training	82,484			82,484		82,484		82,484			13
14	Program Transportation					10,882	10,882		10,882			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,444,166	254,330	1,411,013	4,109,509	10,882	4,120,391		4,120,391			16
	C. General Administration											
17	Administrative	202,724		600,530	803,254		803,254	(600,530)	202,724			17
18	Directors Fees											18
19	Professional Services			135,026	135,026		135,026	103,384	238,410			19
20	Dues, Fees, Subscriptions & Promotions			58,427	58,427		58,427	(2,558)	55,869			20
21	Clerical & General Office Expenses	196,152	30,076	390,243	616,471		616,471	20	616,491			21
22	Employee Benefits & Payroll Taxes			832,939	832,939		832,939		832,939			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,343	12,343		12,343		12,343			24
25	Other Admin. Staff Transportation			14,509	14,509	(10,882)	3,627		3,627			25
26	Insurance-Prop.Liab.Malpractice			951,168	951,168		951,168	35,551	986,719			26
27	Other (specify):*											27
28	TOTAL General Administration	398,876	30,076	2,995,185	3,424,137	(10,882)	3,413,255	(464,133)	2,949,122			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,606,290	763,085	6,352,363	10,721,738		10,721,738	(464,133)	10,257,605			29

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

SEE ACCOUNTANTS' PREPARATION 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			21,168	21,168		21,168	368,650	389,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,781	85,781		85,781	176,870	262,651			32
33	Real Estate Taxes							393,059	393,059			33
34	Rent-Facility & Grounds			1,502,641	1,502,641		1,502,641	(1,502,641)				34
35	Rent-Equipment & Vehicles			61,126	61,126		61,126	(1,728)	59,398			35
36	Other (specify):*											36
37	TOTAL Ownership			1,670,716	1,670,716		1,670,716	(565,790)	1,104,926			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			88,006	88,006		88,006		88,006			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			592,212	592,212		592,212		592,212			42
43	Other (specify):* See Schedule 4a			19,961	19,961		19,961	(19,961)				43
44	TOTAL Special Cost Centers			700,179	700,179		700,179	(19,961)	680,218			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,606,290	763,085	8,723,258	13,092,633		13,092,633	(1,049,884)	12,042,749			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2020

Schedule 4a

Page 4 Cost Center Expenses

Line 43 Other Expenses

Contributions	2,500
Penalties	16,250
Travel and Entertainment	1,134
Finance Charges	<u>77</u>

Total Line 43	<u><u>19,961</u></u>
----------------------	-----------------------------

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	85,936	30		9
10	Interest and Other Investment Income	(578)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,327)	43		18
19	Entertainment	(1,134)	43		19
20	Contributions	(2,500)	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 See Pg 5a	(669,400)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (604,003)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(445,881)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (445,881)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,049,884)		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' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Management Fees	\$ (600,530)	17	1
2	Dues and Subscriptions	(2,558)	20	2
3	Auto Leasing	(1,728)	35	3
4	Corporate Taxes	(4,584)	43	4
5	Lobbying	(60,000)	19	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	(669,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Ctr

0042614

Report Period Beginning:

1/1/20

Ending:

12/31/20

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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(600,530)	0	0	0	0	0	0	0	0	0	0	(600,530)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,000)	163,384	0	0	0	0	0	0	0	0	0	103,384	19
20	Fees, Subscriptions & Promotions	(2,558)	0	0	0	0	0	0	0	0	0	0	(2,558)	20
21	Clerical & General Office Expenses	0	20	0	0	0	0	0	0	0	0	0	20	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	35,551	0	0	0	0	0	0	0	0	0	35,551	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(663,088)	198,955	0	0	0	0	0	0	0	0	0	(464,133)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(663,088)	198,955	0	0	0	0	0	0	0	0	0	(464,133)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	85,936	282,714	0	0	0	0	0	0	0	0	0	368,650	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(578)	177,448	0	0	0	0	0	0	0	0	0	176,870	32
33	Real Estate Taxes	0	393,059	0	0	0	0	0	0	0	0	0	393,059	33
34	Rent-Facility & Grounds	0	(1,502,641)	0	0	0	0	0	0	0	0	0	(1,502,641)	34
35	Rent-Equipment & Vehicles	(1,728)	0	0	0	0	0	0	0	0	0	0	(1,728)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	83,630	(649,420)	0	0	0	0	0	0	0	0	0	(565,790)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(24,545)	4,584	0	0	0	0	0	0	0	0	0	(19,961)	43
44	TOTAL Special Cost Centers	(24,545)	4,584	0	0	0	0	0	0	0	0	0	(19,961)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(604,003)	(445,881)	0	0	0	0	0	0	0	0	0	(1,049,884)	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		
				Golview 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	\$		100.00%	\$ 35,551	\$ 35,551	1
2	V	30	Depreciation			100.00%	282,714	282,714	2
3	V	32	Interest Expense			100.00%	178,366	178,366	3
4	V	33	Real Estate Taxes			100.00%	393,059	393,059	4
5	V	34	Rent Expense	1,502,641		100.00%		(1,502,641)	5
6	V	19	Professional Fees			100.00%	163,384	163,384	6
7	V	32	Interest Income			100.00%	(918)	(918)	7
8	V	43	Corporate Taxes			100.00%	4,584	4,584	8
9	V	21	Bank Charges			100.00%	20	20	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,502,641			\$ 1,056,760	\$ * (445,881)	14

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

SEE ACCOUNTANTS' PREPARATION 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
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

SEE ACCOUNTANTS' PREPARATION 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	\$ 112,791	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	\$ 112,791		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' PREPARATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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' PREPARATION 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	PR Mortgage and Inv		x	Mortgage			\$ 8,512,723	\$ 6,911,125		2.4500	\$ 174,210	1	
2	PR Mortgage and Inv		x	Mortgage Costs							4,156	2	
3	Interest Income Offset		x								(1,038)	3	
4	state of Illinois		x	Pre-Bankruptcy Fees							10,065	4	
5												5	
	Working Capital												
6	Lake Forest Bank & Trust		x	Working Capital							51,070	6	
7	Chase, Amex, First Insurance		x	Short-term Financing							22,339	7	
8	Anthony Miner	x		Short-term Financing							1,849	8	
9	TOTAL Facility Related						\$ 8,512,723	\$ 6,911,125			\$ 262,651	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,512,723	\$ 6,911,125			\$ 262,651	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 35,551 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' PREPARATION REPORT

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042614

CONTACT PERSON REGARDING THIS REPORT _____

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL 6061</u>	\$ <u>365,043.00</u>	\$ _____
2.	<u>09-15-100-012-0000</u>	<u>9555 Golf Road, Des Plaines, IL 6061</u>	\$ <u>45,706.00</u>	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>410,749.00</u></u>	\$ <u><u> </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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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).

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

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		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' PREPARATION REPORT

Facility Name & ID Number Golfview Developmental Ctr

0042614

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FRP installation 1st floor Common Rooms	2016	\$ 65,831	\$	7	\$ 9,404	\$ 9,404	\$ 39,967	37
38	Roofing repairs	2016	6,646		15	443	443	2,215	38
39	First floor door repairs and painting	2016	29,714		7	4,245	4,245	20,517	39
40	Outside repairs, parking lot, sidewalk and landscape	2016	47,797		15	3,186	3,186	14,337	40
41	HVAC and electrical repairs	2016	16,898		7	2,414	2,414	11,467	41
42	Boiler room repairs	2016	24,443		15	1,630	1,630	7,335	42
43	Water fountain repairs	2016	2,582		7	369	369	1,660	43
44	Booster pump installation	2016	16,012		15	1,067	1,067	4,713	44
45	Outdoor handrail repair	2016	13,911		15	927	927	4,017	45
46	Kitchen floor drain repair	2016	47,056		7	6,722	6,722	26,888	46
47	3rd floor activity room cabinets	2016	5,910		7	844	844	3,869	47
48	Painting kitchen and dining room	2017	9,970		10	935	935	3,740	48
49	Repairs for Leaking Roof	2017	39,284		10	3,896	3,896	13,311	49
50	Ceiling Tile Replacement for Kitchen	2017	19,785		10	1,930	1,930	6,755	50
51	Repair Exterior Doors	2017	18,523		10	1,837	1,837	6,276	51
52	Electrical Rewiring for Kitchen	2017	89,947		10	8,847	8,847	30,965	52
53	Wall Replacement in OT Room	2017	12,396		10	1,250	1,250	4,063	53
54	Boiler Repair	2017	35,563		10	3,617	3,617	11,152	54
55	Kitchen Tile Replacement	2017	14,121		10	1,345	1,345	5,156	55
56	FRP Installation 2nd Floor Resident Rooms	2017	19,892		10	1,865	1,865	7,305	56
57	Painting 2nd Floor Bathroom	2017	19,616		10	1,868	1,868	7,005	57
58	FRP Installation 3rd Floor Resident Rooms	2017	17,514		10	1,681	1,681	6,164	58
59	FRP Installation - Utility Room	2017	16,255		10	1,573	1,573	5,768	59
60	Painting 3rd Floor Shower Room	2017	10,859		10	1,051	1,051	3,766	60
61	Painting 3rd Floor Hallways	2017	16,275		10	1,588	1,588	5,690	61
62	Install FRP - 2nd Floor Resident Rooms	2017	19,357		10	1,904	1,904	6,664	62
63	Painting Common Areas	2017	27,188		10	2,763	2,763	8,622	63
64	Install FRP - OT Room	2017	13,799		10	1,391	1,391	4,405	64
65	Fencing	2017	24,454	1,630	10	1,630		5,298	65
66	Rod kitchen drain line	2018	9,809		10	1,015	1,015	3,045	66
67	Install FRP on 2nd Floor Rooms	2018	16,194		10	1,705	1,705	4,688	67
68	Roofing repairs	2018	16,653		10	1,833	1,833	4,277	68
69	2nd Floor Door Repairs	2018	9,303		9	1,034	1,034	2,326	69
70	TOTAL (lines 4 thru 69)		\$ 11,144,406	\$ 3,865		\$ 352,403	\$ 348,538	\$ 7,124,544	70

SEE ACCOUNTANTS' PREPARATION 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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,144,406	\$ 3,865		\$ 352,403	\$ 348,538	\$ 7,124,544	1
2	New Air Conditioner Unit	2020	78,712	96	10	1,312	1,216	1,312	2
3	Parking Lot Resurface	2020	56,286		15	313	313	313	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,279,404	\$ 3,961		\$ 354,028	\$ 350,067	\$ 7,126,169	34

SEE ACCOUNTANTS' PREPARATION 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	\$ 1,444,788	\$ 17,207	\$ 35,178	\$ 17,971	5-10 years	\$ 1,390,395	71
72	Current Year Purchases	9,878		612	612	5-10 years	612	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,454,666	\$ 17,207	\$ 35,790	\$ 18,583		\$ 1,391,007	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)	\$ 12,968,070	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,168	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 389,818	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 368,650	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,517,176	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' PREPARATION 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: \$ 15,382 Description: Ice Maker \$1,176; Copiers \$13,558; Postage Meter \$648
(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	Administrative	2019 Lincoln	\$ 626.00	\$ 7,512	17
18	Resident Transport	2017 Ford	994.00	7,952	18
19	Resident Transport	2017 Chevy	878.00	7,024	19
20	See attached		#####	21,528	20
21	TOTAL		\$ #####	\$ 44,016	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2020

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>
Resident Transport	2018 Chevrolet	835.00	10,020
Resident Transport	2018 Chevrolet	959.00	11,508
		<u>1,794.00</u>	<u>21,528.00</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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	300	150		450
3	Classroom Wages (a)	4,431	7,560		11,991
4	Clinical Wages (b)	2,558	17,010		19,568
5	In-House Trainer Wages (c)	22,975	27,500		50,475
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 30,264	\$ 52,220	\$	\$ 82,484
10	SUM OF line 9, col. 1 and 2 (e)	\$ 82,484			

- (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.

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	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	12
2. From other facilities (f)	
TOTAL TRAINED	26

- (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' PREPARATION 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, C3	visits				88,006		88,006	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			\$		\$	\$ 88,006		\$ 88,006	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' PREPARATION 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	\$ 106,552	\$ 743,667	1
2	Cash-Patient Deposits	282,967	282,967	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,779,452	3,779,452	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,552	43,366	6
7	Other Prepaid Expenses	69,763	69,763	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See attached Schedule 17a</u>	34,854	135,235	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,288,140	\$ 5,054,450	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		9,469,725	14
15	Leasehold Improvements, at Historical Cost	425,325	1,769,387	15
16	Equipment, at Historical Cost	367,946	1,454,666	16
17	Accumulated Depreciation (book methods)	(716,166)	(7,637,795)	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>		186,777	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 77,105	\$ 5,476,760	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,365,245	\$ 10,531,210	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 550,937	\$ 550,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	282,967	282,967	28
29	Short-Term Notes Payable	777,500	777,500	29
30	Accrued Salaries Payable	368,609	368,609	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		205,374	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		4,584	35
	Other Current Liabilities(specify):			
36	<u>Deferred Grant Income</u>	1,613,447	1,613,447	36
37	<u>See Attached Schedule 17a</u>	4,593,943	4,593,943	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,187,403	\$ 8,397,361	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,911,125	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)	\$	\$ 6,911,125	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,187,403	\$ 15,308,486	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,822,158)	\$ (4,777,276)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,365,245	\$ 10,531,210	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2020

Schedule 17a

Page 17 - Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other Current Assets		
Due from Affiliate	34,854	17,725
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	117,510
	<u>34,854</u>	<u>135,235</u>
 Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	186,777
Mortgage Costs, net	-	-
	<u>-</u>	<u>186,777</u>
 Line 36 - Other Current Liabilities		
 Provider Participation Fees Payable	131,745	131,745
Due to 3rd-Party Payor	159,449	159,449
Accrued Management Fees	4,302,749	4,302,749
	<u>4,593,943</u>	<u>4,593,943</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,200,091)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,200,091)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(622,067)	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)	\$ (622,067)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,822,158)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Developmental Ctr

0042614

Report Period Beginning:

1/1/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,889,727	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,889,727	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	448,530	10
11	CNA Training Reimbursements	27,057	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)	\$ 475,587	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	<u>Bedhold Early Discharge</u>	93,214	28
28a	<u>Miscellaneous Income See Sched 19a</u>	12,038	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105,252	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,470,566	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,188,092	31
32	Health Care	4,109,509	32
33	General Administration	3,424,137	33
	B. Capital Expense		
34	Ownership	1,670,716	34
	C. Ancillary Expense		
35	Special Cost Centers	107,967	35
36	Provider Participation Fee	592,212	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,092,633	40
41	Income before Income Taxes (line 30 minus line 40)**	(622,067)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (622,067)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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' PREPARATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2020

Schedule 19a

Page 19 - Income Statement

	<u>Operating</u>	<u>After Consolidation</u>
Line 28a - Miscellaneous Income		
Vending Machines	509	509
Flu Vaccines	(2,000)	(2,000)
Commissary Income	8,269	8,269
Donations Income	-	-
Miscellaneous Income	5,260	5,260
	<u>12,038</u>	<u>12,038</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
2	Assistant Director of Nursing	1,328	1,747	46,752	26.76	2
3	Registered Nurses		145	4,342	29.94	3
4	Licensed Practical Nurses	12,933	14,793	431,209	29.15	4
5	CNAs & Orderlies					5
6	CNA Trainees	2,336	2,336	29,263	12.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,737	2,017	35,362	17.53	9
10	Activity Assistants	5,017	6,291	88,695	14.10	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,657	2,008	52,588	26.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,119	13,344	196,845	14.75	15
16	Dishwashers					16
17	Maintenance Workers	1,893	1,925	42,153	21.90	17
18	Housekeepers	26,494	28,696	422,921	14.74	18
19	Laundry	2,963	3,219	48,741	15.14	19
20	Administrator	1,952	2,160	89,933	41.64	20
21	Assistant Administrator					21
22	Other Administrative	2,664	2,929	54,495	18.61	22
23	Office Manager	2,003	2,160	65,974	30.54	23
24	Clerical	4,842	5,536	75,683	13.67	24
25	Vocational Instruction					25
26	Academic Instruction	1,872	2,398	53,221	22.19	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,037	11,429	214,707	18.79	28
29	Resident Services Coordinator	1,176	1,192	33,634	28.22	29
30	Habilitation Aides (DD Homes)	87,609	96,333	1,482,146	15.39	30
31	Medical Records	1,865	2,103	24,835	11.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Executive Director</u>	1,848	2,080	112,791	54.23	33
34	TOTAL (lines 1 - 33)	185,345	204,841	\$ 3,606,290 *	\$ 17.61	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	179	\$ 9,370	L1, C3	35
36	Medical Director	12	14,400	L9, C3	36
37	Medical Records Consultant	19	829	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,240	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	630	L11, C3	44
45	Social Service Consultant	208	14,560	L12, C3	45
46	Other(specify) <u>Psychologist</u>	10	734	L10, C3	46
47	<u>Psychiatrist</u>	5	1,000	L10, C3	47
48	<u>Dietary Staffing (Temp)</u>	5,440	158,696	L1, C3	48
49	TOTAL (lines 35 - 48)	5,931	\$ 203,459		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	521	42,242	L10, C3	51
52	Certified Nurse Assistants/Aides	36,634	1,333,378	L10, C3	52
53	TOTAL (lines 50 - 52)	37,155	\$ 1,375,620		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Golfview Developmental Ctr

STATE OF ILLINOIS

0042614

Report Period Beginning:

1/1/20

Page 21

Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	100	\$ 112,791
Theodise Harris	Asst. Administrator	0	89,933
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 202,724

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
Warady & Davis LLP	Accounting	\$ 15,210
Ben Lazarre	Consulting	60,000
CSC	Legal	121
Fox Rothschild LLP	Legal	395
Hall Prangle + Schoonveld LLC	Legal	2,279
Hepler Broom LLC	Legal	378
Holland & Knight	Legal	4,294
Michigan Peer Review	Professional	1,485
Personell Planners	Human Resources	1,687
Polsinelli Shughart	Legal	49,177
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 135,026

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 36,219
Unemployment Compensation Insurance	16,395
FICA Taxes	267,844
Employee Health Insurance	247,669
Employee Meals	63,221
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	116,667
Other Employee Benefits	84,924
TOTAL (agree to Schedule V, line 22, col.8)	\$ 832,939

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	34,946
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Illinois Health Care Association	5,885
Cook County	1,357
Illinois Secretary of State	486
Illinois State Police	1,201
Other	11,994
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 55,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	12,343
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 12,343

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

XX. GENERAL INFORMATION:

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

(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

(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? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,639 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. \$ 592,210
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 63,221 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? _____
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 for Leased Owner 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. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Warady & Davis LLP

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT