FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0042614

Facility Name: Golfview Development Center

Address: 9555 West Golf Road (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rocco Losch **Telephone Number:** (847)267-9600
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/25 to 12/31/25 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	135	Intermediate (ICF)	135	49,275	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF									8
9	SNF/PED									9
10	ICF	42,434							42,434	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	42,434							42,434	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 86.12%

D. How many bed reserve days during this year were paid by the Department?
700 (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 [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

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 [x] Date 11/17/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	396,860	56,908	82,091	535,859		535,859		535,859			1
2	Food Purchase		467,587		467,587	(81,160)	386,427		386,427			2
3	Housekeeping	581,105	68,635		649,740		649,740		649,740			3
4	Laundry	58,853	21,704		80,557		80,557		80,557			4
5	Heat and Other Utilities			259,567	259,567		259,567		259,567			5
6	Maintenance	33,346	20,423	297,089	350,858		350,858	(34,931)	315,927			6
7	Other (specify):*			47,194	47,194		47,194		47,194			7
8	**TOTAL General Services**	1,070,164	635,257	685,941	2,391,362	(81,160)	2,310,202	(34,931)	2,275,271			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,333,357	171,614	2,444,135	5,949,106	(47,716)	5,901,390		5,901,390			10
10a	Therapy											10a
11	Activities	233,396	4,348	756	238,500		238,500		238,500			11
12	Social Services			12,712	12,712		12,712		12,712			12
13	CNA Training	56,569			56,569	47,716	104,285		104,285			13
14	Program Transportation					8,625	8,625		8,625			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,623,322	175,962	2,472,003	6,271,287	8,625	6,279,912		6,279,912			16
	C. General Administration											
17	Administrative	222,313		736,213	958,526		958,526	(736,213)	222,313			17
18	Directors Fees											18
19	Professional Services			429,896	429,896		429,896	(43,621)	386,275			19
20	Dues, Fees, Subscriptions & Promotions			69,398	69,398		69,398	(4,728)	64,670			20
21	Clerical & General Office Expenses	241,931	21,855	488,067	751,853		751,853		751,853			21
22	Employee Benefits & Payroll Taxes			974,139	974,139	81,160	1,055,299		1,055,299			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,410	15,410		15,410		15,410			24
25	Other Admin. Staff Transportation			11,500	11,500	(8,625)	2,875		2,875			25
26	Insurance-Prop.Liab.Malpractice			601,759	601,759		601,759	29,383	631,142			26
27	Other (specify):*											27
28	**TOTAL General Administration**	464,244	21,855	3,326,382	3,812,481	72,535	3,885,016	(755,179)	3,129,837			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,157,730	833,074	6,484,326	12,475,130		12,475,130	(790,110)	11,685,020			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.

Facility Name & ID Number Golfview Development Center #0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,552	31,552		31,552	306,141	337,693			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,469	10,469		10,469	121,967	132,436			32
33	Real Estate Taxes							505,397	505,397			33
34	Rent-Facility & Grounds			1,207,872	1,207,872		1,207,872	(1,207,872)				34
35	Rent-Equipment & Vehicles			80,457	80,457		80,457	(523)	79,934			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,330,350	1,330,350		1,330,350	(274,890)	1,055,460			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,513	7,513		7,513		7,513			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			719,628	719,628		719,628		719,628			42
43	Other (specify):* **See Attached pg 4a**			1,411	1,411		1,411	(1,411)				43
44	**TOTAL Special Cost Centers**			728,552	728,552		728,552	(1,411)	727,141			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,157,730	833,074	8,543,228	14,534,032		14,534,032	(1,066,411)	13,467,621			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, 2024

Schedule 4a

Page 4 Cost Center Expenses

Line 43 Other Expenses

Travel and Entertainment	443
Finance Charges	968
Total Line 43	1,411

See Accountants' Compilation Report

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	75,419	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(968)	43		18
19	Entertainment	(443)	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	(5,160)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule pg 5a	(841,395)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (772,547)		$	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)	(293,864)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (293,864)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,066,411)		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

Golfview Development Center

ID# 0042614

Report Period Beginning: 1/1/25

Ending: 12/31/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (4,421)	20	1
2	Other Expenses Related to Lobbying Activities	(65,000)	19	2
3	Management Fees	(736,213)	17	3
4	Auto Leasing	(523)	35	4
5	Lobbyist Registration	(307)	20	5
6	Repairs capitalized for Medicaid Purposes	(34,931)	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**	(841,395)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(34,931)	0	0	0	0	0	0	0	0	0	0	(34,931)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(34,931)	0	0	0	0	0	0	0	0	0	0	(34,931)	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	(736,213)	0	0	0	0	0	0	0	0	0	0	(736,213)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(65,000)	21,379	0	0	0	0	0	0	0	0	0	(43,621)	19
20	Fees, Subscriptions & Promotions	(4,728)	0	0	0	0	0	0	0	0	0	0	(4,728)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	29,383	0	0	0	0	0	0	0	0	0	29,383	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(805,941)	50,762	0	0	0	0	0	0	0	0	0	(755,179)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(840,872)	50,762	0	0	0	0	0	0	0	0	0	(790,110)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Development Center # 0042614 **Report Period Beginning:** 1/1/25 **Ending:** 12/31/25

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	75,419	230,722	0	0	0	0	0	0	0	0	0	306,141	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	121,967	0	0	0	0	0	0	0	0	0	121,967	32
33	Real Estate Taxes	0	505,397	0	0	0	0	0	0	0	0	0	505,397	33
34	Rent-Facility & Grounds	0	(1,207,872)	0	0	0	0	0	0	0	0	0	(1,207,872)	34
35	Rent-Equipment & Vehicles	(523)	0	0	0	0	0	0	0	0	0	0	(523)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	74,896	(349,786)	0	0	0	0	0	0	0	0	0	(274,890)	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):*	(6,571)	5,160	0	0	0	0	0	0	0	0	0	(1,411)	43
44	**TOTAL Special Cost Centers**	(6,571)	5,160	0	0	0	0	0	0	0	0	0	(1,411)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(772,547)	(293,864)	0	0	0	0	0	0	0	0	0	(1,066,411)	45

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 Partnership d/b/a Golfview Partnership Venture	Chicago	Real Estate

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$		100.00%	$ 29,383	$ 29,383	1
2	V	30	Depreciation			100.00%	230,722	230,722	2
3	V	32	Interest Expense			100.00%	145,754	145,754	3
4	V	33	Real Estate Taxes			100.00%	505,397	505,397	4
5	V	34	Rent Expense	1,207,872		100.00%		(1,207,872)	5
6	V	19	Professional Fees			100.00%	21,379	21,379	6
7	V	32	Interest Income			100.00%	(23,787)	(23,787)	7
8	V	43	Corporate Taxes			100.00%	5,160	5,160	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,207,872			$ 914,008	$ * (293,864)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS **Ownership Listing-1**

Golfview Development Center

ID# **0042614**

Report Period Beginning: **1/1/25**

Ending: **12/31/25**

ARM Management Inc

Golfview Realty Partnership

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Anthony		Miner	Chicago	IL	100.00000	50.03000	100.00000	1
2	Greg		Miner	Chicago	IL	0.00000	49.97000	0.00000	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
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38									38
39									39
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41									41
42									42
43									43
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65									65
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67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Golfview Development Center

ID# **0042614**

Report Period Beginning: **1/1/25**

Ending: **12/31/25**

ARM Management, Inc.

Golfview Realty Partnership

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
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89									89
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91									91
92									92
93									93
94									94
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98									98
99									99
100									100
101									101
102									102
103									103
104									104
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111									111
112									112
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114									114
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116									116
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119									119
120									120
121									121
122									122
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131									131
132									132
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136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					Golfview Realty	Chicago	Real Estate	1
2					Partnership d/b/a			2
3					Golfview Partnership			3
4					Venture			4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Anthony Miner	President	Executive Director	100.00	None	70-80	100.00	Salary	$ 134,295	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	$ 134,295		13

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

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

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	$ 5,684,479		2.4500	$ 143,987	1
2	PR Mortgage and Inv		x	Mortgage Cost							4,156	2
3	Interest Income and Offset		x								(23,787)	3
4												4
5												5
	Working Capital											
6	State of Illinois		x	Short-term Financing							6,835	6
7	Chase, Amex, First Insurance		x	Short-term Financing							12,740	7
8	Other		x	Short-term Financing							(11,495)	8
9	TOTAL Facility Related						$ 8,512,723	$ 5,684,479			$ 132,436	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	$ 5,684,479			$ 132,436	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 29,383 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.)

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 238,280	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.)		$ 228,677	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,603)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 515,000	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.		$ 505,397	7

Assessed Value from Real Estate Tax Bill:	2024	1,712,313	8
Real Estate Tax Bill for Calendar Year:	2020	470,055	9
	2021	479,330	10
	2022	458,475	11
	2023	476,560	12
	2024	490,785	13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Development Center 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 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-100-013-0000	9555 Golf Road, Des Plaines, IL 6061	$ 446,110.00	$
2.	09-15-100-012-0000	9555 Golf Road, Des Plaines, IL 6061	$ 44,675.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 490,785.00	$

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

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

1. Total Amount Incurred: 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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 Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1997	1997	$ 8,641,370	$	40	$ 216,035	$ 216,035	$ 6,067,014	4
5			1997		(580,616)		39	(14,888)	(14,888)	(410,178)	5
6			1998		40,292		40	1,008	1,008	27,696	6
7	7		1999	1999	52,496		40	1,312	1,312	34,778	7
8											8
	Improvement Type**										
9	Total from 2016 and prior			2016	2,514,107	853		9,570	8,717	2,471,155	9
10	Painting and Kitchen and dining room			2017	9,970		10	935	935	8,415	10
11	Repairs for Leaking Roof			2017	39,284		10	3,896	3,896	32,791	11
12	Ceiling Tile Replacement for Kitchen			2017	19,785		10	1,930	1,930	16,405	12
13	Repair Exterior Doors			2017	18,523		10	1,837	1,837	15,461	13
14	Electrical Rewiring for Kitchen			2017	89,947		10	8,847	8,847	75,200	14
15	Wall Replacement in OT Room			2017	12,396		10	1,250	1,250	10,313	15
16	Boiler Repair			2017	35,563		10	3,617	3,617	29,237	16
17	Kitchen Tile Replacement			2017	14,121		10	1,345	1,345	11,881	17
18	FRP Installation 2nd Floor Resident Rooms			2017	19,892		10	1,865	1,865	16,630	18
19	Painting 2nd Floor Bathroom			2017	19,616		10	1,868	1,868	16,345	19
20	FRP Installation 3rd Floor Resident Rooms			2017	17,514		10	1,681	1,681	14,569	20
21	FRP Installation - Utility Room			2017	16,255		10	1,573	1,573	13,633	21
22	Painting 3rd Floor Shower Room			2017	10,859		10	1,051	1,051	9,021	22
23	Painting 3rd Floor Hallways			2017	16,275		10	1,588	1,588	13,630	23
24	Install FRP - 2nd Floor Resident Rooms			2017	19,357		10	1,904	1,904	16,184	24
25	Painting Common Areas			2017	27,188		10	2,763	2,763	22,437	25
26	Install FRP - OT Room			2017	13,799		10	1,391	1,391	11,360	26
27	Fencing			2017	24,454	1,630	10	1,630		13,448	27
28	Rod Kitchen drain line			2018	9,809		10	1,015	1,015	8,120	28
29	Install FRP on 2nd Floor Rooms			2018	16,194		10	1,705	1,705	13,213	29
30	Roofing repairs			2018	16,653		10	1,833	1,833	13,442	30
31	2nd Floor Door Repairs			2018	9,303		9	1,034	1,034	7,496	31
32	New Air Conditioner Unit			2020	78,712	574	10	7,871	7,297	40,668	32
33	Parking Lot Resurface			2020	56,286		15	3,752	3,752	19,073	33
34	Boiler Fuse			2021	49,856	4,986	10	4,986		20,359	34
35	New Compressor			2022	30,678		10	3,068	3,068	9,972	35
36	New Pump			2022	5,984		10	598	598	1,944	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler Repairs	2022	$ 6,557	$	5	$ 1,174	$ 1,174	$ 4,501	37
38	Generator Repairs	2022	6,253		5	1,191	1,191	4,169	38
39	Motor Control Repairs	2022	3,146		5	651	651	2,007	39
40	Main Door Repairs	2022	2,670		5	552	552	1,702	40
41	Electrical Panel Repaid	2022	10,458		5	2,202	2,202	6,606	41
42	Fire Pump Controller	2022	4,928		5	969	969	3,229	42
43	Boiler Repairs	2024	18,565		5	5,304	5,304	10,166	43
44	Electrical Repairs	2024	7,300		5	2,737	2,737	2,965	44
45	Kitchen Electrical Repairs	2024	3,485		5	1,101	1,101	1,743	45
46	Doors	2024	5,913		5	1,731	1,731	3,173	46
47	Elevator Repairs	2024	6,390		5	1,870	1,870	3,429	47
48	Fire Pump Repairs	2024	5,144		5	1,816	1,816	2,270	48
49	Plumbing Repairs	2024	26,603		5	8,868	8,868	12,563	49
50	New Boiler	2025	60,023	513	5	513		513	50
51	Smoke Damper	2025	22,704	568	5	568		568	51
52	Kitchen Exhaust Fan	2025	18,296		5	1,525	1,525	1,525	52
53	Replaced Air Vent Room 301	2025	16,635		5	990	990	990	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,590,992	$ 9,124		$ 313,632	$ 304,508	$ 8,733,831	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	$ 1,562,957	$ 22,213	$ 23,846	$ 1,633	5-10 years	$ 1,479,269	71
72	Current Year Purchases	3,594	215	215		5-10 years	215	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,566,551	$ 22,428	$ 24,061	$ 1,633		$ 1,479,484	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)	$ 13,391,543	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,552	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 337,693	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 306,141	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,213,315	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.

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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: *

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.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 10,545 Description: Medical Equipment $259, Postage Meter $220, Copier $10,066
(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	2022 Lincoln	$ 793.00	$ 4,758	17
18	Administrative	2025 Lincoln	#######	8,183	18
19	Resident Transport	2024 Ford	#######	56,448	19
20					20
21	TOTAL		$ #######	$ 69,389	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

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] 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 [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		100	475		575
3	Classroom Wages	(a)	2,359	14,060		16,419
4	Clinical Wages	(b)	3,011	28,120		31,131
5	In-House Trainer Wages	(c)	6,178	49,982		56,160
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 11,648	$ 92,637	$	$ 104,285
10	SUM OF line 9, col. 1 and 2	(e)	$ 104,285			

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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	23

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' 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				5,717		5,717	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): Optical Services	L39,C3					691		691	12
13	Other (specify): Hearing Services	L39,C3					1,105		1,105	13
14	TOTAL			$		$	$ 7,513		$ 7,513	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

STATE OF ILLINOIS

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/25 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,341,415	$ 1,652,357	1
2	Cash-Patient Deposits	335,674	335,674	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,030,684	8,030,684	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,035	63,603	6
7	Other Prepaid Expenses	113,743	113,743	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Schedule 17a	45,315	327,493	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,906,866	$ 10,523,554	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		8,157,966	14
15	Leasehold Improvements, at Historical Cost	557,908	2,044,313	15
16	Equipment, at Historical Cost	477,070	1,566,551	16
17	Accumulated Depreciation (book methods)	(826,224)	(8,996,866)	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	2,419,121	679,055	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,627,875	$ 3,685,019	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,534,741	$ 14,208,573	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,371,027	$ 1,371,027	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	341,134	341,134	28
29	Short-Term Notes Payable	1,050,000	1,050,000	29
30	Accrued Salaries Payable	546,787	546,787	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		515,000	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	6,740,797	4,634,194	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,049,745	$ 8,458,142	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,684,479	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Long-term Lease Liability	1,088,716		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,088,716	$ 5,684,479	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,138,461	$ 14,142,621	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,396,280	$ 65,952	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,534,741	$ 14,208,573	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2025

Schedule 17a

Page 17 - Balance Sheet	**Operating**	**After Consolidation**
Line 9 - Other Current Assets		
Due from Affiliate	45,315	-
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	327,493
	45,315	327,493
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	679,055
Right of Use Asset	2,419,121	-
	2,419,121	679,055
Line 37 - Other Current Liabilities		
Advances from Affiliate	777,127	-
Provider Participation Fees Payable	70,338	70,338
Due to 3rd-Party Payor	90,458	90,458
Accrued Management Fees	4,472,469	4,472,469
Accrued Illinois Replacement Tax	-	929
Lease Liability	1,330,405	-
	6,740,797	4,634,194

See Accountants' Compilation Report

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 675,380	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 675,380	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	760,900	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	(40,000)	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)**	$ 720,900	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)**	$ 1,396,280	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,139,527	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,139,527	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		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)**	$	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**	63,669	28
28a	**Miscellaneous Income - see schedule 19a**	91,736	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 155,405	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,294,932	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,391,362	31
32	Health Care	6,271,287	32
33	General Administration	3,812,481	33
	B. Capital Expense		
34	Ownership	1,330,350	34
	C. Ancillary Expense		
35	Special Cost Centers	7,513	35
36	Provider Participation Fee	719,628	36
	D. Other Expenses (specify):		
37	**Entertainment & Fees**	1,411	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,534,032	40
41	**Income before Income Taxes (line 30 minus line 40)****	760,900	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 760,900	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	56

SEE ACCOUNTANTS' PREPARATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #042614
December 31, 2025

Schedule 19a

Page 19 - Income Statement	**Operating**	**After Consolidation**
Line 28a - Miscellaneous Income		
Donations Income	1,206	1,206
Commissary Income	9,166	9,166
Miscellaneous Income	193	193
Training Income	81,140	81,140
Other Patient Income	31	31
	91,736	91,736

See Accountants' Compilation Report

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,344	1,360	$ 64,998	$ 47.79	1
2	Assistant Director of Nursing	2,104	2,160	97,883	45.32	2
3	Registered Nurses	4,645	4,747	191,797	40.40	3
4	Licensed Practical Nurses	5,372	5,508	212,034	38.50	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,105	2,155	50,516	23.44	9
10	Activity Assistants	8,793	9,003	182,880	20.31	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,024	2,080	56,815	27.31	13
14	Head Cook	5,543	5,651	109,272	19.34	14
15	Cook Helpers/Assistants	12,160	12,334	230,773	18.71	15
16	Dishwashers					16
17	Maintenance Workers	1,779	1,824	33,346	18.28	17
18	Housekeepers	29,359	29,993	581,105	19.37	18
19	Laundry	2,520	2,562	58,853	22.97	19
20	Administrator	2,024	2,080	88,018	42.32	20
21	Assistant Administrator					21
22	Other Administrative	2,369	2,430	62,613	25.77	22
23	Office Manager	2,024	2,080	77,084	37.06	23
24	Clerical	5,347	5,460	102,234	18.72	24
25	Vocational Instruction					25
26	Academic Instruction	2,018	2,074	56,569	27.28	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	11,251	11,552	295,647	25.59	28
29	Resident Services Coordinator	2,011	2,067	61,542	29.77	29
30	Habilitation Aides (DD Homes)	109,528	111,785	2,368,419	21.19	30
31	Medical Records	2,100	2,156	41,037	19.03	31
32	Other Health Care(specify)					32
33	Other(specify) executive director	2,024	2,080	134,295	64.56	33
34	TOTAL (lines 1 - 33)	218,444	223,141	$ 5,157,730 *	$ 23.11	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 7,279	L1,C3	35
36	Medical Director	48	14,400	L9,C3	36
37	Medical Records Consultant	21	1,332	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	16	756	L11,C3	44
45	Social Service Consultant	178	12,712	L12,C3	45
46	Other(specify) Dietary Staffing (temp	2,582	74,812	L1,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,020	$ 114,531		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,142	$ 77,066	L10,C3	50
51	Licensed Practical Nurses	629	35,237	L10,C3	51
52	Certified Nurse Assistants/Aides	62,543	2,326,850	L10,C3	52
53	TOTAL (lines 50 - 52)	64,314	$ 2,439,153		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Executive Director	100	$ 134,295
Daniel Knefley	Administrator	0	88,018
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 222,313

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
Ben Lazare	Consulting	$ 65,000
Cray Huber Hortsman Heil & Van A	Legal	2,181
Diana Falero	Legal	72,500
Ford Harrison	Legal	11,589
Hilary Farrell	Legal	100,000
Holland & Knight	Legal	2,171
Ice Miller	Legal	73,375
Kerr Consulting	IT Consulting	86,665
O'HaganMeyer	Legal	1,249
Personnel Planners	Legal	1,282
Warady & Davis LLP	Accounting	18,000
Other	Legal	(4,116)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 429,896

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,978
Unemployment Compensation Insurance	16,585
FICA Taxes	406,592
Employee Health Insurance	390,949
Employee Meals	81,160
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	126,035
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,055,299

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	42,054
Health Care Worker Background Check	2,694
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	11,097
Cook County	1,012
Illinois Office of the State Fire Marshall	429
Secretary of State	991
Other	10,814
Less: Public Relations Expense	( )
PAC and Lobbying payments	(4,421)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,670

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Golfview Development Center # 0042614 Report Period Beginning: 1/1/25 Ending: 12/31/25

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	6,676
	6,676 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	4,421
	4,421 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	11,097
	11,097 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 71,113 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 719,628
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 81,160 Has any meal income been offset against related costs? No Indicate the amount. $

(12) 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. $

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 Lincoln lease to owner

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? Indicate the amount of income earned from providing such transportation during this reporting period. $ No

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

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

(15) 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.