

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0042614

Facility Name: Golfview Developmental Center

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

County: Cook

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

HFS ID Number: 362935353001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 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) <u>Warady & Davis LLP</u> <u>1717 Deerfield Road, Suite 300 So., Deerfield, IL 60015</u>	
	(Telephone) <u>(847)267-9600</u> Fax # <u>(847)267-9696</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614 Report Period Beginning: 1/1/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>135</u>	Intermediate/DD	<u>135</u>	<u>49,275</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>135</u>	TOTALS	<u>135</u>	<u>49,275</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>48,289</u>			<u>48,289</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>48,289</u>			<u>48,289</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.00%

D. How many bed-hold days during this year were paid by the Department? 910 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 11/17/97

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/06 Ending: 12/31/06

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	267,858	32,393	7,812	308,063		308,063		308,063			1
2	Food Purchase		189,223		189,223		189,223		189,223			2
3	Housekeeping	349,498	56,651		406,149		406,149		406,149			3
4	Laundry	29,745	14,353	154	44,252		44,252		44,252			4
5	Heat and Other Utilities			194,834	194,834		194,834		194,834			5
6	Maintenance	46,627	23,049	85,459	155,135		155,135		155,135			6
7	Other (specify):*											7
8	TOTAL General Services	693,728	315,669	288,259	1,297,656		1,297,656		1,297,656			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,144,752	48,792	188,911	2,382,455		2,382,455		2,382,455			10
10a	Therapy			17,284	17,284		17,284		17,284			10a
11	Activities	72,765	7,503	74,888	155,156		155,156		155,156			11
12	Social Services	12,164		6,538	18,702		18,702		18,702			12
13	CNA Training	93,104			93,104		93,104		93,104			13
14	Program Transportation			427	427	22,292	22,719		22,719			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,322,785	56,295	300,048	2,679,128	22,292	2,701,420		2,701,420			16
	C. General Administration											
17	Administrative	173,625		413,226	586,851		586,851	(413,226)	173,625			17
18	Directors Fees											18
19	Professional Services			440,202	440,202		440,202	23,682	463,884			19
20	Dues, Fees, Subscriptions & Promotions			79,480	79,480		79,480	(1,120)	78,360			20
21	Clerical & General Office Expenses	151,260	33,757	43,196	228,213		228,213	(381)	227,832			21
22	Employee Benefits & Payroll Taxes			763,817	763,817		763,817		763,817			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,180	4,180		4,180		4,180			24
25	Other Admin. Staff Transportation			29,723	29,723	(22,292)	7,431		7,431			25
26	Insurance-Prop.Liab.Malpractice			98,284	98,284		98,284	45,080	143,364			26
27	Other (specify):*											27
28	TOTAL General Administration	324,885	33,757	1,872,108	2,230,750	(22,292)	2,208,458	(345,965)	1,862,493			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,341,398	405,721	2,460,415	6,207,534		6,207,534	(345,965)	5,861,569			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Golfview Developmental Center #0042614 Report Period Beginning: 1/1/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			38,549	38,549	38,549	339,805	378,354			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			29,631	29,631	29,631	502,793	532,424			32
33	Real Estate Taxes						267,404	267,404			33
34	Rent-Facility & Grounds			1,180,227	1,180,227	1,180,227	(1,180,227)				34
35	Rent-Equipment & Vehicles			49,671	49,671	49,671	(2,211)	47,460			35
36	Other (specify):*										36
37	TOTAL Ownership			1,298,078	1,298,078	1,298,078	(72,436)	1,225,642			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		4,367		4,367	4,367		4,367			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			425,548	425,548	425,548		425,548			42
43	Other (specify):*			6,819	6,819	6,819	(6,819)				43
44	TOTAL Special Cost Centers		4,367	432,367	436,734	436,734	(6,819)	429,915			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,341,398	410,088	4,190,860	7,942,346	7,942,346	(425,220)	7,517,126			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning: 1/1/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	881	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,541)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,972)	43		19
20	Contributions	(1,350)	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	(1,026)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(200)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(417,209)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (425,417)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	197		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 197		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (425,220)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/1/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Management Fees	\$ (413,226)	17	1
2	Dues & Subscriptions	(1,120)	20	2
3	Finance Charges	(271)	43	3
4	Bank Charges	(381)	21	4
5	Rental Expense	(2,211)	35	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	(417,209)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06

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

	Operating Expenses	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)	
	A. General Services													
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	(413,226)	0	0	0	0	0	0	0	0	0	0	(413,226)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	23,682	0	0	0	0	0	0	0	0	0	23,682	19
20	Fees, Subscriptions & Promotions	(1,120)	0	0	0	0	0	0	0	0	0	0	(1,120)	20
21	Clerical & General Office Expenses	(381)	0	0	0	0	0	0	0	0	0	0	(381)	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	45,080	0	0	0	0	0	0	0	0	0	45,080	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(414,727)	68,762	0	0	0	0	0	0	0	0	0	(345,965)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(414,727)	68,762	0	0	0	0	0	0	0	0	0	(345,965)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	881	338,924	0	0	0	0	0	0	0	0	0	339,805	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,541)	505,334	0	0	0	0	0	0	0	0	0	502,793	32
33	Real Estate Taxes	0	267,404	0	0	0	0	0	0	0	0	0	267,404	33
34	Rent-Facility & Grounds	0	(1,180,227)	0	0	0	0	0	0	0	0	0	(1,180,227)	34
35	Rent-Equipment & Vehicles	(2,211)	0	0	0	0	0	0	0	0	0	0	(2,211)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,871)	(68,565)	0	(72,436)	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):*	(6,819)	0	0	0	0	0	0	0	0	0	0	(6,819)	43
44	TOTAL Special Cost Centers	(6,819)	0	0	0	0	0	0	0	0	0	0	(6,819)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(425,417)	197	0	(425,220)	45								

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bertram Miner	100			Golfview Realty	Chicago	Real Estate
				Partnership d/b/a		
				Golfview Venture		
				Partnership		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	26 Insurance	\$	Golfview Realty Partnership	100.00%	\$ 45,080	\$ 45,080	1
2	V	30 Depreciation		Golfview Realty Partnership	100.00%	338,924	338,924	2
3	V	32 Interest Expense		Golfview Realty Partnership	100.00%	508,161	508,161	3
4	V	33 Real Estate Taxes		Golfview Realty Partnership	100.00%	267,404	267,404	4
5	V	32 Interest Income	2,827	Golfview Realty Partnership	100.00%		(2,827)	5
6	V	34 Rent Expense	1,180,227	Golfview Realty Partnership	100.00%		(1,180,227)	6
7	V	19 Professional Fees		Golfview Realty Partnership	100.00%	23,682	23,682	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,183,054			\$ 1,183,251	\$ * 197	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	None	None	70-80	100.00	Salary	\$ 93,922	17,1	1
2											2
3	*Son of Bertram Miner										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,922		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Capstone Realty Advisors		X	Mortgage	\$48,209.00	4/17/03	\$ 9,225,000	\$	5/31/2043	5.6000	\$ 504,781	1						
2	Capstone Realty Advisors		X	Mortgage Costs							3,380	2						
3	First Insurance Funding Corp		X	Insurance Financing							537	3						
4	Interest Income Offset		X								(2,946)	4						
5	Shareholder Loan	X		Working Capital	Interest Only	Various	786,009	945,009	Demand	9.2500	29,213	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$48,209.00		\$ 10,011,009	\$ 945,009			\$ 534,965	9						
B. Non-Facility Related*																		
10	Shareholder Loan	X		Working Capital - Excess interest over Prime paid to related party							(2,541)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(2,541)	14						
15	TOTALS (line 9+line14)						\$ 10,011,009	\$ 945,009			\$ 532,424	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 45,080 Line # 26

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042614

CONTACT PERSON REGARDING THIS REPORT Anthony Miner

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-15-100-012-0000</u>	<u>9555 Golf Road, Des Plaines, IL</u>	<u>\$ 24,330.68</u>	<u>\$ 24,330.68</u>
2. <u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL</u>	<u>\$ 229,724.12</u>	<u>\$ 229,724.12</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 254,054.80	\$ 254,054.80

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Golfview Developmental Center

0042614 Report Period Beginning:

1/1/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Residential Care</u>	<u>117,000</u>	<u>1977</u>	<u>\$ 234,000</u>	1
2					2
3	TOTALS	117,000		\$ 234,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center# 0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	128		1997	1977	\$ 8,641,370	\$	40	\$ 216,034	\$ 216,034	\$ 1,962,362	4
5			1997		(580,616)		39	(14,887)	(14,887)	(127,313)	5
6			1998		40,292		40	1,007	1,007	8,561	6
7	7		1999	1999	52,495		40	1,312	1,312	9,841	7
8											8
	Improvement Type**										
9	Fencing		1997		1,200	120	10	120		1,140	9
10	Lobby notice board		1998		3,380	338	10	338		2,873	10
11	Parking Lot		1998		139,900		15	9,327	9,327	79,278	11
12	Exhaust System		1999		2,801		10	280	280	2,100	12
13	Compressor		1999		11,972		10	1,197	1,197	8,979	13
14	Fencing		1999		1,800		10	180	180	1,350	14
15	Fire Vents		1999		1,806		10	181	181	1,356	15
16	Elevator		1999		932		10	93	93	699	16
17	Security System		1999		970		10	97	97	728	17
18	Heating Unit		2000		715		10	72	72	466	18
19	Security system		2000		2,017		10	202	202	1,312	19
20	Telephone Line		2000		7,234		10	723	723	4,701	20
21	Security system		2000		2,087	209	10	209		1,355	21
22	Specialty Wiring & Oxygen Lines		2001		567,060		10	56,706	56,706	340,236	22
23	Security System		2001		4,803	481	10	481		2,642	23
24	Security System		2001		17,731	1,773	10	1,773		9,752	24
25	Fire Alarm System		2001		7,583	758	10	758		4,170	25
26	Security System		2002		4,402	440	10	440		1,980	26
27	Hot Water Tanks		2002		3,142	314	10	314		1,413	27
28	Hot Water Pipes		2003		9,150	915	10	915		3,355	28
29	Title and Wall Coverings		2003		4,190	419	10	419		1,397	29
30	Door		2003		3,624	362	10	362		1,206	30
31	Resident Room Repair		2003		5,314	531	10	531		1,593	31
32	2 new faucets		2004		2,308	231	10	231		693	32
33	Floor Repair		2004		5,966	597	10	597		1,691	33
34	Drywall		2004		6,749	675	10	675		1,912	34
35	Repair Walls		2004		15,133	1,513	10	1,513		3,533	35
36	Dishwasher		2004		2,850	285	10	285		689	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Piping Repairs and Replace	2004	\$ 3,458	\$ 346	10	\$ 346	\$	\$ 750	37
38	Entry System	2005	3,700	370	10	370		740	38
39	Fire Damper Access Hatch	2005	20,122	2,012	10	2,012		2,683	39
40	Floor repair & Replace	2005	2,290	229	10	229		248	40
41	Stairwell Construction	2006	120,795	10,066	10	10,066		10,066	41
42	Kitchen Improvments	2006	12,735	955	10	955		955	42
43	New Dock Door	2006	5,982	449	10	449		449	43
44	Kitchen Improvments	2006	6,000	100	10	100		100	44
45	Gauges	2006	2,768	138	10	138		138	45
46	Kitchen Improvments	2006	5,320	187	10	187		187	46
47									47
48									48
49									49
50									50
51									51
52									52
53									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)		\$ 9,173,530	\$ 24,813		\$ 297,337	\$ 272,524	\$ 2,352,366	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 941,219	\$ 12,712	\$ 80,118	\$ 67,406	5-10 years	\$ 840,866	71
72	Current Year Purchases	11,358	899	899		5-10 years	899	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 952,577	\$ 13,611	\$ 81,017	\$ 67,406		\$ 841,765	75

D. Vehicle Depreciation (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)	\$ 10,360,107	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,424	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 378,354	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 339,930	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,194,131	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 8,044 Description: Copier \$5,844; Postage Meter \$388, Ice Machine \$1,812

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transport	2004 Ecoline Van	\$ 651.00	\$ 8,462	17
18	Resident Transport	2004 Ford Ecoline Van	604.00	7,852	18
19	Resident Transport	2006 Ford Ecoline Van	635.00	8,255	19
20	See Attached 14a			14,847	20
21	TOTAL		\$ #####	\$ 39,416	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.

GOLFVIEW DEVELOPMENTAL CENTER, INC.

Provider #0042614

December 31, 2006

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 Transportation	2006 Ford Econoline Van	635.00	8,255
Administrative	2003 Acura	455.00	5,472
Administrative	2007 Acura	560.00	1,120
			<hr/> <hr/> 14,847

See Accountants' Compilation Report

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>90</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	1,450	950		2,400
3	Classroom Wages (a)	9,829	6,552		16,381
4	Clinical Wages (b)	21,877	14,584		36,461
5	In-House Trainer Wages (c)	24,089	15,783		39,872
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 57,245	\$ 37,869	\$	\$ 95,114
10	SUM OF line 9, col. 1 and 2 (e)	\$ 95,114			

C. CONTRACTUAL INCOME

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

\$ NONE

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>38</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>58</u>
2. From other facilities (f)	
TOTAL TRAINED	96

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

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

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

	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	L39, C2	visits				3,402		3,402	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Optical	L39, C2					965		965	13
14	TOTAL			\$		\$	\$ 4,367	\$	\$ 4,367	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center# 0042614Report Period Beginning: 1/1/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,324	\$ 35,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,147,424	2,147,424	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,185	25,899	6
7	Other Prepaid Expenses	34,776	34,776	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule 17a</u>		40,215	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,191,709	\$ 2,284,283	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		8,710,554	14
15	Leasehold Improvements, at Historical Cost	284,043	423,943	15
16	Equipment, at Historical Cost	162,209	952,578	16
17	Accumulated Depreciation (book methods)	(154,402)	(3,186,583)	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>		450,178	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 291,850	\$ 7,584,670	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,483,559	\$ 9,868,953	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 489,895	\$ 491,272	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,049	254,049	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		139,730	32
33	Accrued Interest Payable	10,312	10,312	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17a</u>	4,280,328	3,562,534	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,034,584	\$ 4,457,897	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,979,966	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,979,966	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,034,584	\$ 13,437,863	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,551,025)	\$ (3,568,910)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,483,559	\$ 9,868,953	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.

Provider #0042614

December 31, 2006

Schedule 17a

Page 17 - Balance Sheet

	<u>Operating</u>	<u>After Consolidation</u>
Line 9 - Other Current Assets		
Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	40,215
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	332,960
Mortgage Costs, net	-	117,218
	<u>-</u>	<u>450,178</u>
Line 36 - Other Current Liabilities		
Due to Shareholders	945,009	945,009
Provider Participation Fees Payable	217,971	217,971
Due to 3rd-Party Payor	267,305	267,305
Accrued Management Fees	2,132,249	2,132,249
Due to Affiliates	717,794	-
	<u>4,280,328</u>	<u>3,562,534</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,903,177)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,903,177)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(647,848)	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)	\$ (647,848)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,551,025)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center# 0042614Report Period Beginning: 1/1/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,114,372	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,114,372	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	51,196	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)	\$ 51,196	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>	128,930	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 128,930	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,294,498	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,297,656	31
32	Health Care	2,679,128	32
33	General Administration	2,230,750	33
B. Capital Expense			
34	Ownership	1,298,078	34
C. Ancillary Expense			
35	Special Cost Centers	11,186	35
36	Provider Participation Fee	425,548	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,942,346	40
41	Income before Income Taxes (line 30 minus line 40)**	(647,848)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (647,848)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

GOLFVIEW DEVELOPMENTAL CENTER, INC.

Provider #0042614

December 31, 2006

Schedule 19a

Net loss for the year per page 19 does not agree to taxable loss on the Federal Income Tax Return because this entity is a cash basis taxpayer.

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/06

Ending:

12/31/06

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	901	917	\$ 36,105	\$ 39.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,602	1,701	39,643	23.31	3
4	Licensed Practical Nurses	10,815	11,673	299,536	25.66	4
5	CNAs & Orderlies	1,962	2,082	20,672	9.93	5
6	CNA Trainees	6,486	6,486	52,842	8.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,944	3,468	39,511	11.39	8
9	Activity Director	1,875	1,960	28,461	14.52	9
10	Activity Assistants	4,339	4,794	44,304	9.24	10
11	Social Service Workers	1,803	2,080	12,164	5.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,855	2,080	39,668	19.07	14
15	Cook Helpers/Assistants	20,274	22,182	228,190	10.29	15
16	Dishwashers					16
17	Maintenance Workers	3,338	3,481	46,627	13.39	17
18	Housekeepers	25,260	27,958	349,498	12.50	18
19	Laundry	1,950	2,284	29,745	13.02	19
20	Administrator	1,768	2,080	93,922	45.15	20
21	Assistant Administrator	1,916	2,080	79,703	38.32	21
22	Other Administrative	1,780	2,080	36,987	17.78	22
23	Office Manager	1,892	2,080	49,255	23.68	23
24	Clerical	4,476	4,687	65,018	13.87	24
25	Vocational Instruction					25
26	Academic Instruction	1,800	2,120	40,262	18.99	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,965	15,087	228,524	15.15	28
29	Resident Services Coordinator	1,857	2,226	34,222	15.37	29
30	Habilitation Aides (DD Homes)	135,216	144,606	1,446,539	10.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	250,074	270,192	\$ 3,341,398 *	\$ 12.37	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	168	\$ 7,812	L1, C3	35
36	Medical Director	96	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	52	7,985	L10, C3	39
40	Physical Therapy Consultant	33	1,788	L10A, C3	40
41	Occupational Therapy Consultant	109	5,934	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	163	9,562	L10A, C3	43
44	Activity Consultant	1,183	74,888	L11, C3	44
45	Social Service Consultant	131	6,538	L12, C3	45
46	Other(specify) <u>Psychologist</u>	75	8,207	L10, C3	46
47	<u>Psychiatrist</u>	72	2,800	L10, C3	47
48	<u>Pharmacist</u>	48	3,240	L10, C3	48
49	TOTAL (lines 35 - 48)	2,130	\$ 140,754		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	400	\$ 21,183	L10, C3	50
51	Licensed Practical Nurses	1,074	55,322	L10, C3	51
52	Certified Nurse Assistants/Aides	4,846	90,174	L10, C3	52
53	TOTAL (lines 50 - 52)	6,320	\$ 166,679		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning: 1/1/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Anthony Miner	Administrator		\$ 93,922	Workers' Compensation Insurance	\$ 90,281	IDPH License Fee	\$		
Barbara Waters	Asst. Administrator		79,703	Unemployment Compensation Insurance	47,273	Advertising: Employee Recruitment	51,374		
				FICA Taxes	253,087	Health Care Worker Background Check			
				Employee Health Insurance	196,118	(Indicate # of checks performed <u>245</u>)	4,904		
				Employee Meals	40,956	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	7,452		
				Union Health & Welfare	79,263	Miscellaneous Licenses and Fees	10,000		
				Other Employee Benefits	56,839	Miscellaneous Licenses and Fees	4,318		
						Illinois Secretary of State	312		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 173,625			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 78,360	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 763,817		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Line #	Amount	
C. Professional Services							Description		Amount
Vendor/Payee	Type		Amount						
Becky Gibson	Legal		\$ 100				Out-of-State Travel		\$
Foley Lardner	Legal		59,569						
Friedman and Wexler LLC	Legal		(17)				In-State Travel		
Personnel Planners	HR Consultants		1,239						
Shefsky & Froelich	Legal		179,077				Seminar Expense		4,180
US Department of Justice	Bankruptcy Fee		24,000						
Warady & Davis LLP	Accounting Fees		25,050				Entertainment Expense		()
Wildman, Harrold, Allen & Dixon	Legal		170,387				(agree to Sch. V, line 24, col. 8)		
Wiss, Janney, Elstner Associates, Inc	Architecture Fees		4,479				TOTAL		\$ 4,180
TOTAL (agree to Schedule V, line 19, column 3)			\$ 463,884	TOTAL			\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Golfview Developmental Center

Report Period Beginning: 1/1/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association \$7452
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,076 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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 425,548
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. \$ 40,956 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. \$ 177
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes, Except Acura
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT