

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 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 1/1/07 to 12/31/07 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, Ste 300 South, 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: 1/1/07 Ending: 12/31/07

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>48,039</u>			<u>48,039</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>48,039</u>			<u>48,039</u>

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

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

968 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/17/97

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/17/97 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	264,552	36,757	7,140	308,449		308,449		308,449			1
2	Food Purchase		161,976		161,976		161,976		161,976			2
3	Housekeeping	315,735	55,072		370,807		370,807		370,807			3
4	Laundry	28,383	15,905		44,288		44,288		44,288			4
5	Heat and Other Utilities			260,688	260,688		260,688		260,688			5
6	Maintenance	40,437	26,555	135,725	202,717		202,717		202,717			6
7	Other (specify):*											7
8	TOTAL General Services	649,107	296,265	403,553	1,348,925		1,348,925		1,348,925			8
	B. Health Care and Programs											
9	Medical Director			7,458	7,458		7,458		7,458			9
10	Nursing and Medical Records	1,977,068	45,349	551,059	2,573,476		2,573,476		2,573,476			10
10a	Therapy			15,357	15,357		15,357		15,357			10a
11	Activities	57,312	9,951	92,084	159,347		159,347		159,347			11
12	Social Services	11,502		5,988	17,490		17,490		17,490			12
13	CNA Training	79,490			79,490		79,490		79,490			13
14	Program Transportation					21,840	21,840		21,840			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,125,372	55,300	671,946	2,852,618	21,840	2,874,458		2,874,458			16
	C. General Administration											
17	Administrative	174,524		417,403	591,927		591,927	(417,403)	174,524			17
18	Directors Fees											18
19	Professional Services			311,053	311,053		311,053	13,800	324,853			19
20	Dues, Fees, Subscriptions & Promotions			64,025	64,025		64,025	(1,826)	62,199			20
21	Clerical & General Office Expenses	145,802	35,980	89,541	271,323		271,323	(167)	271,156			21
22	Employee Benefits & Payroll Taxes			755,408	755,408		755,408		755,408			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,682	2,682		2,682		2,682			24
25	Other Admin. Staff Transportation			29,120	29,120	(21,840)	7,280		7,280			25
26	Insurance-Prop.Liab.Malpractice			98,781	98,781		98,781	44,689	143,470			26
27	Other (specify):*											27
28	TOTAL General Administration	320,326	35,980	1,768,013	2,124,319	(21,840)	2,102,479	(360,907)	1,741,572			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,094,805	387,545	2,843,512	6,325,862		6,325,862	(360,907)	5,964,955			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: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,570	45,570		45,570	313,223	358,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,495	16,495		16,495	498,413	514,908			32
33	Real Estate Taxes							270,355	270,355			33
34	Rent-Facility & Grounds			1,189,308	1,189,308		1,189,308	(1,189,308)				34
35	Rent-Equipment & Vehicles			46,370	46,370		46,370	(3,209)	43,161			35
36	Other (specify):*											36
37	TOTAL Ownership			1,297,743	1,297,743		1,297,743	(110,526)	1,187,217			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			(957)	(957)		(957)		(957)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			436,539	436,539		436,539		436,539			42
43	Other (specify):* See Attached			1,320	1,320		1,320	(1,320)				43
44	TOTAL Special Cost Centers			436,902	436,902		436,902	(1,320)	435,582			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,094,805	387,545	4,578,157	8,060,507		8,060,507	(472,753)	7,587,754			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2007

Schedule 4a

E. Special Cost Centers	<u>Operating</u>	<u>Adjusted Total</u>
Line 43 Other (Specify):		
Non-allowable Contributions	100	-
Non-allowable Meals & Entertainment	1,203	-
Non Allowable Finance Charges	17	-
	<u>1,320</u>	<u>-</u>

See Accountants' Compilation Report

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning: 1/1/07

Ending: 12/31/07

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	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	3,248	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	(3,046)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,203)	43		19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(422,622)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (423,723)		\$	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)	(49,030)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (49,030)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (472,753)		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: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Management Fees	\$ (417,403)	17	1
2	Dues and Subscriptions	(1,826)	20	2
3	Finance Charges	(17)	43	3
4	Bank Charges	(167)	21	4
5	Rental Expense	(3,209)	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	(422,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center# 0042614

Report Period Beginning:

1/1/07

Ending:

12/31/07**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	(417,403)	0	0	0	0	0	0	0	0	0	0	(417,403)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,800	0	0	0	0	0	0	0	0	0	13,800	19
20	Fees, Subscriptions & Promotions	(1,826)	0	0	0	0	0	0	0	0	0	0	(1,826)	20
21	Clerical & General Office Expenses	(167)	0	0	0	0	0	0	0	0	0	0	(167)	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	44,689	0	0	0	0	0	0	0	0	0	44,689	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(419,396)	58,489	0	0	0	0	0	0	0	0	0	(360,907)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(419,396)	58,489	0	0	0	0	0	0	0	0	0	(360,907)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	3,248	309,975	0	0	0	0	0	0	0	0	0	313,223	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,046)	501,459	0	0	0	0	0	0	0	0	0	498,413	32
33	Real Estate Taxes	0	270,355	0	0	0	0	0	0	0	0	0	270,355	33
34	Rent-Facility & Grounds	0	(1,189,308)	0	0	0	0	0	0	0	0	0	(1,189,308)	34
35	Rent-Equipment & Vehicles	(3,209)	0	0	0	0	0	0	0	0	0	0	(3,209)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,007)	(107,519)	0	(110,526)	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):*	(1,320)	0	0	0	0	0	0	0	0	0	0	(1,320)	43
44	TOTAL Special Cost Centers	(1,320)	0	0	0	0	0	0	0	0	0	0	(1,320)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(423,723)	(49,030)	0	(472,753)	45								

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/07

Ending:

12/31/07

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%	\$ 44,689	\$ 44,689	1
2	V	30 Depreciation		Golfview Realty Partnership	100.00%	309,975	309,975	2
3	V	32 Interest Expense		Golfview Realty Partnership	100.00%	503,960	503,960	3
4	V	33 Real Estate Taxes		Golfview Realty Partnership	100.00%	270,355	270,355	4
5	V	32 Interest Income	2,501	Golfview Realty Partnership	100.00%		(2,501)	5
6	V	34 Rent Expense	1,189,308	Golfview Realty Partnership	100.00%		(1,189,308)	6
7	V	19 Professional Fees		Golfview Realty Partnership	100.00%	13,800	13,800	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,191,809			\$ 1,142,779	\$ * (49,030)	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: 1/1/07 Ending: 12/31/07

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	\$ 165,770	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	\$ 165,770		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:

1/1/07

Ending: 12/31/07

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	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	Capstone Realty Advisors		X	Mortgage	\$48,209.00	4/17/03	\$ 9,225,000	\$ 8,902,363	5/31/2043	5.6000	\$ 500,544	1								
2	Capstone Realty Advisors		X	Mortgage Costs							3,416	2								
3	Interest Income Offset		X								(2,940)	3								
4	Shareholder Loan	X		Working Capital	Interest Only	Various	945,009	808,000			16,934	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$48,209.00		\$ 10,170,009	\$ 9,710,363			\$ 517,954	9								
B. Non-Facility Related*																				
10	Shareholder Loan	X		Working Capital - Excess interest over Prime paid to related party							(3,046)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(3,046)	14								
15	TOTALS (line 9+line14)						\$ 10,170,009	\$ 9,710,363			\$ 514,908	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,689 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>25,092.22</u>	\$ <u>25,092.22</u>
2. <u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL</u>	\$ <u>236,913.84</u>	\$ <u>236,913.84</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>262,006.06</u>	\$ <u>262,006.06</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

1/1/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<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:

1/1/07

Ending:

12/31/07**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	\$ 2,178,396	4
5			1997		(580,616)		39	(14,887)	(14,887)	(142,200)	5
6			1998		40,292		40	1,007	1,007	9,568	6
7	7		1999	1999	52,495		40	1,312	1,312	11,153	7
8											8
	Improvement Type**										
9	Fencing		1997		1,200	60	10	60		1,200	9
10	Lobby Notice Board		1998		3,380	338	10	338		3,211	10
11	Parking Lot		1998		139,900		15	9,327	9,327	88,605	11
12	Exhaust System		1999		2,801		10	280	280	2,380	12
13	Compressor		1999		11,972		10	1,197	1,197	10,176	13
14	Fencing		1999		1,800		10	180	180	1,530	14
15	Fire Vents		1999		1,806		10	181	181	1,537	15
16	Elevator		1999		932		10	93	93	792	16
17	Security System		1999		970		10	97	97	825	17
18	Heating Unit		2000		715		10	72	72	538	18
19	Security System		2000		2,017		10	202	202	1,514	19
20	Telephone Line		2000		7,234		10	723	723	5,424	20
21	Security System		2000		2,087	208	10	208		1,563	21
22	Specialty Wiring & Oxygen Lines		2001		567,060		10	56,706	56,706	396,942	22
23	Security System		2001		4,803	480	10	480		3,122	23
24	Security System		2001		17,731	1,773	10	1,773		11,525	24
25	Fire Alarm Systems		2001		7,583	758	10	758		4,928	25
26	Security System		2002		4,402	440	10	440		2,420	26
27	Hot Water Tanks		2002		3,142	314	10	314		1,727	27
28	Hot Water Pipes		2003		9,150	915	10	915		4,270	28
29	Tile and Wall Coverings		2003		4,190	419	10	419		1,816	29
30	Door		2003		3,624	362	10	362		1,568	30
31	Resident Room Repair		2003		5,314	531	10	531		2,124	31
32	2 new Faucets		2003		2,308	231	10	231		924	32
33	Floor repair & replace		2004		5,966	597	10	597		2,288	33
34	Drywall		2004		6,749	675	10	675		2,587	34
35	Remove sound walls		2004		15,133	1,513	10	1,513		5,046	35
36	dishwasher		2004		2,850	285	10	285		974	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:

1/1/07

Ending:

12/31/07

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	2004	\$ 3,458	\$ 346	10	\$ 346	\$	\$ 1,096	37
38	Entry System	2005	3,700	370	10	370		1,110	38
39	Fire Damper Access Hatch	2005	20,122	2,012	10	2,012		4,695	39
40	Floor Repair & Replace	2005	2,290	229	10	229		477	40
41	Stairwell Construction Repair	2006	120,795	12,080	10	12,080		22,146	41
42	Kitchen Improvements	2006	12,735	1,273	10	1,273		2,228	42
43	New Dock Door	2006	5,982	598	10	598		1,047	43
44	Kitchen Improvements	2006	6,000	600	10	600		700	44
45	Gauges	2006	2,768	277	10	277		415	45
46	Kitchen Improvements	2006	5,320	532	10	532		719	46
47	Interior Painting	2007	17,755		5	2,367	2,367	2,367	47
48	Kitchen Improvements	2007	18,996	647	10	647		647	48
49	New Door Installation	2007	30,313	2,273	10	2,273		2,273	49
50	New Fencing	2007	8,076	151	10	151		151	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)		\$ 9,248,670	\$ 31,287		\$ 306,178	\$ 274,891	\$ 2,658,544	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: 1/1/07 Ending: 12/31/07

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	\$ 952,577	\$ 12,951	\$ 51,413	\$ 38,462	5-10 Years	\$ 893,177	71
72	Current Year Purchases	19,856	1,202	1,202		5-10 Years	1,202	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 972,433	\$ 14,153	\$ 52,615	\$ 38,462		\$ 894,379	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)	\$ 10,455,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,440	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 358,793	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 313,353	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,552,923	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 7,780 Description: Copier \$6,216; Postage Meter \$388; Ice Maker \$1,176

(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	<u>Resident Transport</u>	<u>2004 Ecoline Van</u>	\$ <u>651.00</u>	\$ <u>4,556</u>	17
18	<u>Resident Transport</u>	<u>2004 Ford Ecoline Van</u>	<u>604.00</u>	<u>4,228</u>	18
19	<u>Resident Transport</u>	<u>2006 Ford Ecoline Van</u>	<u>635.00</u>	<u>6,985</u>	19
20	<u>See Attached 14a</u>			<u>19,612</u>	20
21	TOTAL		\$ #####	\$ 35,381	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, 2007

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	6,985
Administrative	2007 Acura	560.00	6,720
Resident Transportation	2007 Ford Econoline Van	610.00	2,440
Resident Transportation	2007 Ford Econoline Van	750.00	3,000
Daily Rentals			467
			<hr/>
			19,612
			<hr/> <hr/>

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/07 Ending: 12/31/07

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>40</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>90</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	575	675		1,250
3	Classroom Wages (a)	5,735	6,733		12,468
4	Clinical Wages (b)	12,766	14,986		27,752
5	In-House Trainer Wages (c)	18,014	21,148		39,162
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 37,090	\$ 43,542	\$	\$ 80,632
10	SUM OF line 9, col. 1 and 2 (e)	\$ 80,632			

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>27</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>23</u>
2. From other facilities (f)	
TOTAL TRAINED	50

- (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				(1,468)		(1,468)	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					511		511	13
14	TOTAL			\$		\$	(957)	\$	(957)	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: 1/1/07Ending: 12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ 5,658	\$ 19,539	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,659,490	2,659,490	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,240	41,793	6
7	Other Prepaid Expenses	17,681	17,681	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule 17a</u>		31,128	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,706,069	\$ 2,769,631	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	341,427	499,082	15
16	Equipment, at Historical Cost	182,065	972,434	16
17	Accumulated Depreciation (book methods)	(199,972)	(3,542,128)	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>		396,730	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 323,520	\$ 7,270,672	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,029,589	\$ 10,040,303	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 770,535	\$ 770,535	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,500	247,500	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,103	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17a</u>	4,927,581	3,842,929	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,945,616	\$ 5,005,067	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,902,363	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)	\$	\$ 8,902,363	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,945,616	\$ 13,907,430	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,916,027)	\$ (3,867,127)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,029,589	\$ 10,040,303	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2007

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	-	31,128
	<u>-</u>	<u>31,128</u>
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	282,742
Mortgage Costs, net	-	113,988
	<u>-</u>	<u>396,730</u>
Line 36 - Other Current Liabilities		
Due to Shareholders	808,000	808,000
Provider Participation Fees Payable	217,972	217,972
Due to 3rd-Party Payor	267,305	267,305
Accrued Management Fees	2,549,652	2,549,652
Due to Affiliates	1,084,652	-
	<u>4,927,581</u>	<u>3,842,929</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,551,025)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,551,025)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(365,002)	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)	\$ (365,002)	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)	\$ (2,916,027)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center# 0042614Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 7,518,922	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,518,922	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	40,085	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)	\$ 40,085	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>	136,498	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 136,498	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,695,505	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,348,925	31
32	Health Care	2,852,618	32
33	General Administration	2,124,319	33
B. Capital Expense			
34	Ownership	1,297,743	34
C. Ancillary Expense			
35	Special Cost Centers	363	35
36	Provider Participation Fee	436,539	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,060,507	40
41	Income before Income Taxes (line 30 minus line 40)**	(365,002)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (365,002)	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, 2007

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:

1/1/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,810	2,067	\$ 61,148	\$ 29.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,585	1,674	39,044	23.32	3
4	Licensed Practical Nurses	9,615	10,303	258,397	25.08	4
5	CNAs & Orderlies	1,978	2,116	18,833	8.90	5
6	CNA Trainees	5,229	5,229	40,220	7.69	6
7	Licensed Therapist	4,587	5,174	41,305	7.98	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,794	1,932	28,549	14.78	9
10	Activity Assistants	3,320	3,522	28,763	8.17	10
11	Social Service Workers	1,710	2,072	33,843	16.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,796	2,086	45,214	21.67	14
15	Cook Helpers/Assistants	21,929	23,897	219,338	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,134	3,313	40,437	12.21	17
18	Housekeepers	27,743	30,227	315,735	10.45	18
19	Laundry	1,790	2,099	28,383	13.52	19
20	Administrator	3,329	3,897	165,770	42.54	20
21	Assistant Administrator	255	274	8,754	31.95	21
22	Other Administrative	1,729	2,090	34,787	16.64	22
23	Office Manager	1,821	2,086	47,268	22.66	23
24	Clerical	4,521	4,809	41,406	8.61	24
25	Vocational Instruction					25
26	Academic Instruction	1,820	2,086	39,270	18.83	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,575	15,734	238,309	15.15	28
29	Resident Services Coordinator	2,019	2,071	50,883	24.57	29
30	Habilitation Aides (DD Homes)	127,092	137,938	1,269,149	9.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	245,181	266,696	\$ 3,094,805 *	\$ 11.60	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	154	\$ 7,140	L1, C3	35
36	Medical Director	56	7,458	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	42	3,240	L10, C3	39
40	Physical Therapy Consultant	31	2,335	L10A, C3	40
41	Occupational Therapy Consultant	98	5,850	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	120	7,172	L10A, C3	43
44	Activity Consultant	1,451	92,084	L11, C3	44
45	Social Service Consultant	120	5,988	L12, C3	45
46	Other(specify) <u>Psychologist</u>	139	7,951	L10, C3	46
47	<u>Psychiatrist</u>	48	2,400	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	2,259	\$ 141,618		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	235	\$ 11,644	L10, C3	50
51	Licensed Practical Nurses	2,303	86,322	L10, C3	51
52	Certified Nurse Assistants/Aides	20,258	439,502	L10, C3	52
53	TOTAL (lines 50 - 52)	22,796	\$ 537,468		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning: 1/1/07

Ending: 12/31/07

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		\$ 165,770	Workers' Compensation Insurance	\$ 100,727	IDPH License Fee	\$			
Barbara Water	Asst. Administrator		8,754	Unemployment Compensation Insurance	40,944	Advertising: Employee Recruitment	45,590			
				FICA Taxes	234,268	Health Care Worker Background Check				
				Employee Health Insurance	179,781	(Indicate # of checks performed <u>134</u>)	2,692			
				Employee Meals	33,731	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Heal Care Association	8,073			
				Union Health & Welfare	72,261	Miscellaneous Licenses and Fees	4,723			
				Other Employee Benefits	93,696	Illinois Secretary of State	405			
						Cook County	716			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 174,524			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)		\$ 62,199		
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 755,408			
			\$							
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							
Foley & Lardner LLP	Legal Services		\$ 119,649				Out-of-State Travel		\$	
Shesky & Froelich Ltd.	Legal Services		57,445							
Personnel Planners	Legal Services		3,880							
Friedman & Wexler LLC	Legal Services		(39)				In-State Travel			
Wildman Harrold Allen & Dixon	Legal Services		79,212							
Urban Real Estate Research, Inc.	Appraisal Services		5,000							
U.S. Department of Justice	Trust Fees		30,500							
Warady & Davis, LLP	Accounting Services		25,050				Seminar Expense		2,682	
Deutsch Levy & Engel	Legal Services		4,156							
							Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 324,853	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,682
(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: 1/1/07

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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 Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,100 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 436,539
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. \$ 33,731 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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. \$ 10
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes, Except Owner's Vehicle
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT