

Facility Name & ID Number Golfview Developmental Center

0042614 Report Period Beginning: 1//09 Ending: 12/31/09

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	135	Intermediate/DD	135	49,275	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	48,186			48,186	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,186			48,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.79%

D. How many bed-hold days during this year were paid by the Department? 801 (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: 12/31/09 Fiscal Year: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Golfview Developmental Center

0042614

Report Period Beginning:

1//09

Ending:

12/31/09

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	244,788	37,987	8,837	291,612		291,612	291,612			1
2	Food Purchase		227,778		227,778		227,778	227,778			2
3	Housekeeping	298,078	60,818		358,896		358,896	358,896			3
4	Laundry	28,673	10,073		38,746		38,746	38,746			4
5	Heat and Other Utilities			281,027	281,027		281,027	281,027			5
6	Maintenance	51,176	24,928	272,500	348,604		348,604	(143,935)	204,669		6
7	Other (specify):* Workshop Expense			1,835,097	1,835,097		1,835,097	1,835,097			7
8	TOTAL General Services	622,715	361,584	2,397,461	3,381,760		3,381,760	(143,935)	3,237,825		8
	B. Health Care and Programs										
9	Medical Director			15,527	15,527		15,527	15,527			9
10	Nursing and Medical Records	2,115,394	52,701	32,874	2,200,969	3,662	2,204,631	2,204,631			10
10a	Therapy			14,719	14,719		14,719	14,719			10a
11	Activities	87,126	16,312	100,142	203,580		203,580	203,580			11
12	Social Services			11,628	11,628		11,628	11,628			12
13	CNA Training	92,545			92,545	(1,887)	90,658	90,658			13
14	Program Transportation					25,700	25,700	25,700			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,295,065	69,013	174,890	2,538,968	27,475	2,566,443	2,566,443			16
	C. General Administration										
17	Administrative	180,537		457,742	638,279		638,279	(457,742)	180,537		17
18	Directors Fees										18
19	Professional Services			120,716	120,716		120,716	15,005	135,721		19
20	Dues, Fees, Subscriptions & Promotions			37,793	37,793		37,793	(5,028)	32,765		20
21	Clerical & General Office Expenses	120,611	28,112	106,809	255,532	(1,775)	253,757	253,757			21
22	Employee Benefits & Payroll Taxes			693,312	693,312		693,312	693,312			22
23	Inservice Training & Education			5,903	5,903		5,903	5,903			23
24	Travel and Seminar			34,267	34,267	(25,700)	8,567	8,567			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,632	83,632		83,632	43,866	127,498		26
27	Other (specify):*										27
28	TOTAL General Administration	301,148	28,112	1,540,174	1,869,434	(27,475)	1,841,959	(403,899)	1,438,060		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,218,928	458,709	4,112,525	7,790,162		7,790,162	(547,834)	7,242,328		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			50,547	50,547	50,547	293,196	343,743				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,731	36,731	36,731	454,602	491,333				32
33	Real Estate Taxes						280,630	280,630				33
34	Rent-Facility & Grounds			1,174,130	1,174,130	1,174,130	(1,174,130)					34
35	Rent-Equipment & Vehicles			57,980	57,980	57,980	(6,111)	51,869				35
36	Other (specify):*											36
37	TOTAL Ownership			1,319,388	1,319,388	1,319,388	(151,813)	1,167,575				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			22,916	22,916	22,916		22,916				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			415,326	415,326	415,326		415,326				42
43	Other (specify):* See Attached			41,143	41,143	41,143	(41,143)					43
44	TOTAL Special Cost Centers			479,385	479,385	479,385	(41,143)	438,242				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,218,928	458,709	5,911,298	9,588,935	9,588,935	(740,790)	8,848,145				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, 2009

Schedule 4a

E. Special Cost Centers

	<u>Operating</u>	<u>Adjusted Total</u>
Line 43 Other (Specify):		
Non Allowable Bad Debts	36,482	-
Non Allowable Penalties	50	-
Non-allowable Meals & Entertainment	<u>4,611</u>	<u>-</u>
	<u>41,143</u>	<u>-</u>

See Accountants' Compilation Report

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	21,494	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	(8,031)	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	(4,611)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5 A	(649,348)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (640,496)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(100,294)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (100,294)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (740,790)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Management Fees	\$ (457,742)	17	1
2	Dues and Subscriptions	(5,028)	20	2
3	Bad Debts	(36,482)	43	3
4	Penalties	(50)	43	4
5	Rental Expense	(6,111)	35	5
6	Capitalized Maintenance	(143,935)	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		(649,348)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center# 0042614

Report Period Beginning:

1//09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(143,935)	0	0	0	0	0	0	0	0	0	0	(143,935)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(143,935)	0	0	0	0	0	0	0	0	0	0	(143,935)	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	(457,742)	0	0	0	0	0	0	0	0	0	0	(457,742)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,005	0	0	0	0	0	0	0	0	0	15,005	19
20	Fees, Subscriptions & Promotions	(5,028)	0	0	0	0	0	0	0	0	0	0	(5,028)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	43,866	0	0	0	0	0	0	0	0	0	43,866	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(462,770)	58,871	0	(403,899)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(606,705)	58,871	0	(547,834)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1//09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	21,494	271,702	0	0	0	0	0	0	0	0	0	293,196	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,031)	462,633	0	0	0	0	0	0	0	0	0	454,602	32
33	Real Estate Taxes	0	280,630	0	0	0	0	0	0	0	0	0	280,630	33
34	Rent-Facility & Grounds	0	(1,174,130)	0	0	0	0	0	0	0	0	0	(1,174,130)	34
35	Rent-Equipment & Vehicles	(6,111)	0	0	0	0	0	0	0	0	0	0	(6,111)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,352	(159,165)	0	(151,813)	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):*	(41,143)	0	0	0	0	0	0	0	0	0	0	(41,143)	43
44	TOTAL Special Cost Centers	(41,143)	0	0	0	0	0	0	0	0	0	0	(41,143)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(640,496)	(100,294)	0	0	0	0	0	0	0	0	0	(740,790)	45

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning: 1//09

Ending: 12/31/09

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26 Insurance	\$	Golfview Realty Partnership	100.00%	\$ 43,866	\$ 43,866	1
2	V	30 Depreciation		Golfview Realty Partnership	100.00%	271,702	271,702	2
3	V	32 Interest Expense		Golfview Realty Partnership	100.00%	494,707	494,707	3
4	V	33 Real Estate Taxes		Golfview Realty Partnership	100.00%	280,630	280,630	4
5	V	32 Interest Income	32,074	Golfview Realty Partnership	100.00%		(32,074)	5
6	V	34 Rent Expense	1,174,130	Golfview Realty Partnership	100.00%		(1,174,130)	6
7	V	19 Professional Fees		Golfview Realty Partnership	100.00%	15,005	15,005	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,206,204			\$ 1,105,910	\$ * (100,294)	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//09 Ending: 12/31/09

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	\$ 90,336	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	\$ 90,336		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//09

Ending: 12/31/09

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		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	Midland Loan Services, Inc.		x	Mortgage	\$48,209.00	4/17/03	\$ 9,225,000	\$ 8,733,525	5/31/2043	5.6000	\$ 491,327	1					
2	Midland Loan Services, Inc.		x	Mortgage Costs							3,380	2					
3	Interest Income Offset		x								(9,837)	3					
4	Shareholder Loan	x		Working Capital	Interst Only	Various	808,000	808,000			14,494	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$48,209.00		\$ 10,033,000	\$ 9,541,525			\$ 499,364	9					
B. Non-Facility Related*																	
10	Shareholder Loan	x		Working Capital - Excess interest over Prime paid to related party							(8,031)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (8,031)	14					
15	TOTALS (line 9+line14)						\$ 10,033,000	\$ 9,541,525			\$ 491,333	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,866 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	141,407	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	287,747	2
3. Under or (over) accrual (line 2 minus line 1).	\$	146,340	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	134,290	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	280,630	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	241,341	8
	2005	254,055	9
	2006	262,006	10
	2007	257,103	11
	2008	268,580	12

2008 Tax Assessment 268,580

5% Increase x 1.05

2009 Estimated Taxes 282,009

Use 134,290 (282,009 less 147,719 paid 12/30/2009)

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042614

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847)827-6628 FAX #: (847)727-0948

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(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 6061</u>	\$ <u>23,970.21</u>	\$ <u>23,970.21</u>
2.	<u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL 6061</u>	\$ <u>244,609.41</u>	\$ <u>244,609.41</u>
3.	_____	_____	\$ _____	\$ _____

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>268,579.62</u>	\$ <u>268,579.62</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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//09 Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	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:

1/09

Ending:

12/31/09**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	\$ 2,610,464	4
5			1997		(580,616)		39	(14,887)	(14,887)	(171,975)	5
6			1998		40,292		40	1,007	1,007	11,582	6
7	7		1999	1999	52,495		40	1,312	1,312	13,777	7
8											8
	Improvement Type**										
9		Fencing	1997		1,200		10			1,200	9
10		Lobby Notice Board	1998		3,380		10			3,380	10
11		Parking Lot	1998		139,900		15	9,327	9,327	107,259	11
12		Exhaust System	1999		2,801		10	47	47	2,707	12
13		Compressor	1999		11,972		10	598	598	11,971	13
14		Fencing	1999		1,800		10	90	90	1,800	14
15		Fire Vents	1999		1,806		10	90	90	1,808	15
16		Elevator	1999		932		10	46	46	931	16
17		Security System	1999		970		10	48	48	970	17
18		Heating Unit	2000		715		10	72	72	682	18
19		Security System	2000		2,017		10	202	202	1,918	19
20		Telephone Line	2000		7,234		10	723	723	6,870	20
21		Security System	2000		2,087	208	10	208		1,979	21
22		Specialty Wiring & Oxygen Lines	2001		567,060		10	56,706	56,706	510,354	22
23		Security System	2001		4,803	480	10	480		4,082	23
24		Security System	2001		17,731	1,773	10	1,773		15,071	24
25		Fire Alarm Systems	2001		7,583	758	10	758		6,445	25
26		Security System	2002		4,402	440	10	440		3,301	26
27		Hot Water Tanks	2002		3,142	314	10	314		2,356	27
28		Hot Water Pipes	2003		9,150	915	10	915		6,100	28
29		Tile and Wall Coverings	2003		4,190	419	10	419		2,654	29
30		Door	2003		3,624	363	10	363		2,295	30
31		Resident Room Repair	2003		5,314	532	10	532		3,187	31
32		2 new Faucets	2003		2,308	230	10	230		1,385	32
33		Floor Repair & Replace	2004		5,966	596	10	596		3,480	33
34		Drywall	2004		6,749	675	10	675		3,937	34
35		Remove Sound Walls	2004		15,133	1,513	10	1,513		8,072	35
36		Dishwasher	2004		2,850	285	10	285		1,544	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

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	\$ 345	10	\$ 345	\$	\$ 1,786	37
38	Entry System	2005	3,700	370	10	370		1,850	38
39	Fire Damper Acces Patch	2005	20,122	2,012	10	2,012		8,719	39
40	Floor Repair and Replace	2005	2,290	229	10	229		935	40
41	Stairwell Construction Repair	2006	120,795	12,080	10	12,080		46,305	41
42	Kitchen Improvements	2006	12,735	1,273	10	1,273		4,774	42
43	New Dock Door	2006	5,982	598	10	598		2,243	43
44	Kitchen Improvements	2006	6,000	600	10	600		1,900	44
45	Gauges	2006	2,768	277	10	277		969	45
46	Kitchen Improvements	2006	5,320	532	10	532		1,783	46
47	Interior Painting	2007	17,755		5	3,551	3,551	9,469	47
48	Kitchen Improvements	2007	18,996	1,899	10	1,899		4,445	48
49	New Door Installation	2007	30,313	3,031	10	3,031		8,335	49
50	New Fencing	2007	8,076	808	10	808		1,767	50
51	Interior Painting	2008	77,681		9	8,631	8,631	12,947	51
52	Elevator Pump Repairs	2008	11,875		9	1,319	1,319	1,979	52
53	Ceiling Valves	2008	2,130	213	9	213		213	53
54	Painting	2009	57,865		8	3,617	3,617	3,617	54
55	Parking Lot	2009	12,183		8	888	888	888	55
56	Lobby Repairs	2009	12,485		8	910	910	910	56
57	Bathroom repairs	2009	42,802		8	892	892	892	57
58	Door Repairs	2009	3,438		8				58
59	Freezer Repairs	2009	8,666		8	271	271	271	59
60	Fire Pump	2009	6,496		8	474	474	474	60
61	Fuses	2009	2,772	231	10	231		231	61
62	Door Hinges	2009	6,408	107	10	107		107	62
63	Boiler	2009	4,300	36	10	36		36	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,497,771	\$ 34,142		\$ 326,110	\$ 291,968	\$ 3,299,431	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 1,002,189	\$ 15,351	\$ 16,645	\$ 1,294	5-10 years	\$ 930,255	71
72	Current Year Purchases	10,777	988	988		5-10 years	988	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,012,966	\$ 16,339	\$ 17,633	\$ 1,294		\$ 931,243	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)	\$ 10,744,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,481	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 343,743	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 293,262	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,230,674	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

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/09

Ending: 12/31/09

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 8,492 Description: Copier \$7,122; Postage Meter \$194; 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	Resident Transport	2007 Ford	\$ 610.00	\$ 7,320	17
18	Resident Transport	2007 Ford	750.00	9,000	18
19	Resident Transport	2009 Ford	895.00	10,740	19
20	See attached 14a			16,317	20
21	TOTAL		\$ #####	\$ 43,377	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2009

Schedule 14a

Page 14 - Vehicle Rental

<u>Use</u>	<u>Model Year & Make</u>	<u>Monthly Lease Payment</u>	<u>Rental Expense for this period</u>
Administrative	2007 Acura	560.00	5,040
Administrative	2009 Acura	579.00	1,737
Resident Transport	2009 Ford Ecoline	795.00	9,540
			<hr/> <hr/> 16,317

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1//09 Ending: 12/31/09
 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	800	975		1,775
3	Classroom Wages (a)	6,651	12,480		19,131
4	Clinical Wages (b)	6,476	28,080		34,556
5	In-House Trainer Wages (c)	15,863	19,333		35,196
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 29,790	\$ 60,868	\$	\$ 90,658
10	SUM OF line 9, col. 1 and 2 (e)	\$ 90,658			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	39
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	32
2. From other facilities (f)	
TOTAL TRAINED	71

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$										1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care	L39, C2	visits							22,916					22,916	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	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$		\$		\$	22,916			\$	22,916			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

0042614

Report Period Beginning: 1//09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 438,923	\$ 688,595	1
2	Cash-Patient Deposits	106,291	106,291	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,721,855	2,721,855	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,591	26,793	6
7	Other Prepaid Expenses	24,960	24,960	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule 17a</u>		11,013	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,300,620	\$ 3,579,507	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	357,037	748,183	15
16	Equipment, at Historical Cost	222,597	1,012,966	16
17	Accumulated Depreciation (book methods)	(299,722)	(4,188,978)	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>		225,689	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 279,912	\$ 6,742,414	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,580,532	\$ 10,321,921	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 399,983	\$ 399,983	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	106,291	106,291	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	308,724	308,724	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		134,290	32
33	Accrued Interest Payable	125	125	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule 17a</u>	6,069,971	4,740,170	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,885,094	\$ 5,689,583	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,733,525	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)	\$	\$ 8,733,525	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,885,094	\$ 14,423,108	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,304,562)	\$ (4,101,187)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,580,532	\$ 10,321,921	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2009

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	-	11,013
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	118,161
Mortgage Costs, net	-	107,528
	-	225,689
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	267,413	267,413
Accrued Management Fees	3,446,785	3,446,785
Due to Affiliates	1,329,801	-
	6,069,971	4,740,170

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,303,780)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,303,780)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(782)	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)	\$ (782)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,304,562)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,408,021	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,408,021	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	50,264	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)	\$ 50,264	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Early Discharge	113,669	28
28a	Miscellaneous Income See Attached Pg 19A	16,199	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 129,868	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,588,153	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,381,760	31
32	Health Care	2,566,443	32
33	General Administration	1,841,959	33
B. Capital Expense			
34	Ownership	1,319,388	34
C. Ancillary Expense			
35	Special Cost Centers	64,059	35
36	Provider Participation Fee	415,326	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,588,935	40
41	Income before Income Taxes (line 30 minus line 40)**	(782)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (782)	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, 2009

Schedule 19a

Page 19 - Income Statement	<u>Operating</u>	<u>After Consolidation</u>
Line 28a - Miscellaneous Income		
Flu Vaccines	3,954	3,954
Miscellaneous Income	500	500
Vending Machines	1,913	1,913
Commissary Income	<u>9,832</u>	<u>9,832</u>
	<u>16,199</u>	<u>16,199</u>

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/09

Ending:

12/31/09

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	1,831	2,085	\$ 62,913	\$ 30.17	1
2	Assistant Director of Nursing	247	308	9,923	32.22	2
3	Registered Nurses					3
4	Licensed Practical Nurses	13,259	14,268	355,922	24.95	4
5	CNAs & Orderlies	1,616	1,790	17,349	9.69	5
6	CNA Trainees	6,749	6,749	53,543	7.93	6
7	Licensed Therapist	3,533	4,260	36,526	8.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,085	31,392	15.06	9
10	Activity Assistants	6,181	6,555	55,246	8.43	10
11	Social Service Workers	30	30	488	16.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,825	2,086	44,098	21.14	14
15	Cook Helpers/Assistants	21,024	22,867	200,690	8.78	15
16	Dishwashers					16
17	Maintenance Workers	3,718	4,055	51,176	12.62	17
18	Housekeepers	27,267	29,858	298,078	9.98	18
19	Laundry	1,806	2,100	28,673	13.65	19
20	Administrator	3,929	4,166	180,537	43.34	20
21	Assistant Administrator					21
22	Other Administrative	1,975	2,108	31,994	15.18	22
23	Office Manager	1,834	2,086	48,628	23.31	23
24	Clerical	4,524	4,734	39,989	8.45	24
25	Vocational Instruction					25
26	Academic Instruction	1,809	2,086	39,002	18.70	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,618	16,064	234,150	14.58	28
29	Resident Services Coordinator	1,812	2,086	48,425	23.21	29
30	Habilitation Aides (DD Homes)	143,196	154,297	1,350,186	8.75	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	264,692	286,723	\$ 3,218,928 *	\$ 11.23	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	2,268	\$ 8,837	L1, C3	35
36	Medical Director	89	15,527	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	2,692	L10, C3	39
40	Physical Therapy Consultant	46	3,422	L10A, C3	40
41	Occupational Therapy Consultant	41	2,391	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	175	8,906	L10A, C3	43
44	Activity Consultant	1,426	100,142	L11, C3	44
45	Social Service Consultant	213	11,628	L12, C3	45
46	Other(specify) <u>Psychologist</u>		3,822	L10, C3	46
47	<u>Psychiatrist</u>		2,400	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	4,294	\$ 159,767		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	61	2,590	L10, C3	51
52	Certified Nurse Assistants/Aides	1,703	21,370	L10, C3	52
53	TOTAL (lines 50 - 52)	1,764	\$ 23,960		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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# 0042614

Report Period Beginning:

1//09

Ending:

12/31/09**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, \$7,452
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,204 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 415,326 paid
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. \$ 49,823 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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes, except owners vehicle
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
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
- (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