

Facility Name & ID Number Golfview Developmental Center

0042614 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	48,054			48,054	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,054			48,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.52%

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

635 (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: 12/31/10 Fiscal Year: 12/31/10

* 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:

1/1/10

Ending:

12/31/10

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	242,910	36,755	8,489	288,154		288,154		288,154		1
2	Food Purchase		242,773		242,773		242,773		242,773		2
3	Housekeeping	281,783	54,855		336,638		336,638		336,638		3
4	Laundry	28,082	7,687	197	35,966		35,966		35,966		4
5	Heat and Other Utilities			258,224	258,224		258,224		258,224		5
6	Maintenance	52,227	21,240	150,095	223,562		223,562	(35,259)	188,303		6
7	Other (specify):* Workshop Expense			1,880,034	1,880,034		1,880,034		1,880,034		7
8	TOTAL General Services	605,002	363,310	2,297,039	3,265,351		3,265,351	(35,259)	3,230,092		8
	B. Health Care and Programs										
9	Medical Director			15,993	15,993		15,993		15,993		9
10	Nursing and Medical Records	2,094,097	52,818	8,576	2,155,491		2,155,491		2,155,491		10
10a	Therapy			10,391	10,391		10,391		10,391		10a
11	Activities	95,939	14,055	41,060	151,054		151,054		151,054		11
12	Social Services			10,850	10,850		10,850		10,850		12
13	CNA Training	96,102			96,102	3,181	99,283		99,283		13
14	Program Transportation			384	384	27,480	27,864		27,864		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,286,138	66,873	87,254	2,440,265	30,661	2,470,926		2,470,926		16
	C. General Administration										
17	Administrative	175,597		457,444	633,041		633,041	(457,444)	175,597		17
18	Directors Fees										18
19	Professional Services			233,757	233,757		233,757	18,548	252,305		19
20	Dues, Fees, Subscriptions & Promotions			30,256	30,256		30,256	(5,307)	24,949		20
21	Clerical & General Office Expenses	113,404	33,948	168,718	316,070	(3,181)	312,889		312,889		21
22	Employee Benefits & Payroll Taxes			736,343	736,343		736,343		736,343		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,880	5,880		5,880		5,880		24
25	Other Admin. Staff Transportation			36,640	36,640	(27,480)	9,160		9,160		25
26	Insurance-Prop.Liab.Malpractice			85,893	85,893		85,893	43,418	129,311		26
27	Other (specify):*										27
28	TOTAL General Administration	289,001	33,948	1,754,931	2,077,880	(30,661)	2,047,219	(400,785)	1,646,434		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,180,141	464,131	4,139,224	7,783,496		7,783,496	(436,044)	7,347,452		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:

1/1/10

Ending:

12/31/10

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			53,236	53,236		53,236	304,520	357,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,193	46,193		46,193	452,940	499,133			32
33	Real Estate Taxes							279,543	279,543			33
34	Rent-Facility & Grounds			1,200,222	1,200,222		1,200,222	(1,200,222)				34
35	Rent-Equipment & Vehicles			59,526	59,526		59,526	(2,365)	57,161			35
36	Other (specify):*											36
37	TOTAL Ownership			1,359,177	1,359,177		1,359,177	(165,584)	1,193,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			16,698	16,698		16,698		16,698			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			422,084	422,084		422,084		422,084			42
43	Other (specify):* See Attached			4,451	4,451		4,451	(4,451)				43
44	TOTAL Special Cost Centers			443,233	443,233		443,233	(4,451)	438,782			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,180,141	464,131	5,941,634	9,585,906		9,585,906	(606,079)	8,979,827			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, 2010

Schedule 4a

E. Special Cost Centers

	<u>Operating</u>	<u>Adjusted Total</u>
Line 43 Other (Specify):		
Non Allowable Finance Charges	323	-
Non-allowable Meals & Entertainment	<u>4,128</u>	<u>-</u>
	<u>4,451</u>	<u>-</u>

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	23,949	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	(9,772)	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	(4,128)	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 <u>PG5 A</u>	(500,698)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (490,649)		\$	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)	(115,430)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (115,430)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (606,079)		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

BHF USE ONLY							
48		49		50		51	

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/1/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

	Amount	Reference	Sch. V Line
1 Management Fees	\$ (457,444)	17	1
2 Dues and Subscriptions	(5,307)	20	2
3 Finance Charges	(323)	43	3
4 Rental Expense	(2,365)	35	4
5 Capitalized Maintenance	(35,259)	6	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	(500,698)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	(35,259)	0	0	0	0	0	0	0	0	0	0	(35,259)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(35,259)	0	0	0	0	0	0	0	0	0	0	(35,259)	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	(457,444)	0	0	0	0	0	0	0	0	0	0	(457,444)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18,548	0	0	0	0	0	0	0	0	0	18,548	19
20	Fees, Subscriptions & Promotions	(5,307)	0	0	0	0	0	0	0	0	0	0	(5,307)	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	43,418	0	0	0	0	0	0	0	0	0	43,418	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(462,751)	61,966	0	(400,785)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(498,010)	61,966	0	(436,044)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Center# 0042614

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	23,949	280,571	0	0	0	0	0	0	0	0	0	304,520	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,772)	462,712	0	0	0	0	0	0	0	0	0	452,940	32
33	Real Estate Taxes	0	279,543	0	0	0	0	0	0	0	0	0	279,543	33
34	Rent-Facility & Grounds	0	(1,200,222)	0	0	0	0	0	0	0	0	0	(1,200,222)	34
35	Rent-Equipment & Vehicles	(2,365)	0	0	0	0	0	0	0	0	0	0	(2,365)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,812	(177,396)	0	(165,584)	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):*	(4,451)	0	0	0	0	0	0	0	0	0	0	(4,451)	43
44	TOTAL Special Cost Centers	(4,451)	0	0	0	0	0	0	0	0	0	0	(4,451)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(490,649)	(115,430)	0	(606,079)	45								

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 Partnership		
				Venture		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	26 Insurance	\$	Golfview Realty Partnership	100.00%	\$ 43,418	\$	43,418	1
2	V	30 Depreciation		Golfview Realty Partnership	100.00%	280,571		280,571	2
3	V	32 Interest Expense		Golfview Realty Partnership	100.00%	489,548		489,548	3
4	V	33 Real Estate Taxes		Golfview Realty Partnership	100.00%	279,543		279,543	4
5	V	32 Interest Income	26,836	Golfview Realty Partnership	100.00%			(26,836)	5
6	V	34 Rent Expense	1,200,222	Golfview Realty Partnership	100.00%			(1,200,222)	6
7	V	19 Professional Fees		Golfview Realty Partnership	100.00%	18,548		18,548	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 1,227,058			\$ 1,111,628	\$ *	(115,430)	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:

1/1/10

Ending:

12/31/10

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	\$ 94,712	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	\$ 94,712		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:

1/1/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

0042614

Report Period Beginning:

1/1/10

Ending:

12/31/10

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										
										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	\$ 8,641,761	5/31/2043	5.6000	\$ 486,318	1							
2	Midland Loan Services, Inc.		x	Mortgage Costs							3,230	2							
3	Interest Income Offset		x								(2,269)	3							
4	Shareholder Loan	x		Working Capital	Interest Only	Various	808,000	808,000			15,269	4							
5	Bankruptcy & Insurance	x		Working Capital	Interest Only	n/a					6,357	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$48,209.00		\$ 10,033,000	\$ 9,449,761			\$ 508,905	9							
B. Non-Facility Related*																			
10	Shareholder Loan	x		Working Capital - Excess interest over Prime paid to related party							(9,772)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (9,772)	14							
15	TOTALS (line 9+line14)						\$ 10,033,000	\$ 9,449,761			\$ 499,133	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,418 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 must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	<u>134,290</u>	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.)		\$	<u>276,869</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>142,579</u>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>136,964</u>	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.		\$	<u>279,543</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<u>254,055</u>	8
	2006	<u>262,006</u>	9
	2007	<u>257,103</u>	10
	2008	<u>268,580</u>	11
	2009	<u>273,927</u>	12

2009 Tax Assessment 273,927

5% Increase x 1.05

2010 Estimated Taxes 287,624

Use 136,964 (287,624 less 150,660 paid 12/31/10)

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		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

2009 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 2009 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 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-15-100-012-0000</u>	<u>9555 Golf Road, Des Plaines, IL 60010</u>	\$ <u>18,112.00</u>	\$ <u>18,112.00</u>
2. <u>09-15-100-013-0000</u>	<u>9555 Golf Road, Des Plaines, IL 60010</u>	\$ <u>255,815.00</u>	\$ <u>255,815.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>273,927.00</u></u>	\$ <u><u>273,927.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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:

1/1/10

Ending:

12/31/10

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:

1/1/10

Ending:

12/31/10

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	\$ 2,826,498	4
5			1997		(580,616)		39	(14,887)	(14,887)	(186,862)	5
6			1998		40,292		40	1,007	1,007	12,589	6
7	7		1999	1999	52,495		40	1,312	1,312	15,089	7
8											8
	Improvement Type**										
9	Fencing		1997		1,200		10			1,200	9
10	Lobby Notice Board		1998		3,380		15			3,380	10
11	Parking Lot		1998		139,900		15	9,327	9,327	116,586	11
12	Exhaust System		1999		2,801		10			2,707	12
13	Compressor		1999		11,972		10			11,971	13
14	Fencing		1999		1,800		10			1,800	14
15	Fire Vents		1999		1,806		10			1,808	15
16	Elevator		1999		932		10			931	16
17	Security System		1999		970		10			970	17
18	Heating Unit		2000		715		10	12	12	694	18
19	Security System		2000		2,017		10	50	50	1,968	19
20	Telephone Line		2000		7,234		10	362	362	7,232	20
21	Security System		2000		2,087	106	10	106		2,085	21
22	Specialty Wiring & Oxygen Lines		2001		567,060		10	56,706	56,706	567,060	22
23	Security System		2001		4,803	480	10	480		4,562	23
24	Security System		2001		17,731	1,773	10	1,773		16,844	24
25	Fire Alarm Systems		2001		7,583	758	10	758		7,203	25
26	Security System		2002		4,402	440	10	440		3,741	26
27	Hot Water Tanks		2002		3,142	314	10	314		2,670	27
28	Hot Water Pipes		2003		9,150	915	10	915		7,015	28
29	Tile and Wall Coverings		2003		4,190	419	10	419		3,073	29
30	Door		2003		3,624	362	10	362		2,657	30
31	Resident Room Repair		2003		5,314	531	10	531		3,718	31
32	2 new Faucets		2003		2,308	231	10	231		1,616	32
33	Floor Repair & Replace		2004		5,966	597	10	597		4,077	33
34	Drywall		2004		6,749	675	10	675		4,612	34
35	Remove Sound Walls		2004		15,133	1,513	10	1,513		9,585	35
36	Dishwasher		2004		2,850	285	10	285		1,829	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:

1/1/10

Ending:

12/31/10

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

1	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	\$	\$ 2,132	37
38 Entry System	2005	3,700	370	10	370		2,220	38
39 Fire Damper Acces Patch	2005	20,122	2,012	10	2,012		10,731	39
40 Floor Repair and Replace	2005	2,290	229	10	229		1,164	40
41 Stairwell Construction Repair	2006	120,795	12,080	10	12,080		58,385	41
42 Kitchen Improvements	2006	12,735	1,273	10	1,273		6,047	42
43 New Dock Door	2006	5,982	598	10	598		2,841	43
44 Kitchen Improvements	2006	6,000	600	10	600		2,500	44
45 Gauges	2006	2,768	277	10	277		1,246	45
46 Kitchen Improvements	2006	5,320	532	10	532		2,315	46
47 Interior Painting	2007	17,755		5	3,551	3,551	13,020	47
48 Kitchen Improvements	2007	18,996	1,899	10	1,899		6,344	48
49 New Door Installation	2007	30,313	3,031	10	3,031		11,366	49
50 New Fencing	2007	8,076	808	10	808		2,575	50
51 Interior Painting	2008	77,681		9	8,631	8,631	21,578	51
52 Elevator Pump Repairs	2008	11,875		9	1,319	1,319	3,298	52
53 Ceiling Valves	2008	2,130	213	9	213		426	53
54 Painting	2009	57,865		8	7,233	7,233	10,850	54
55 Parking Lot	2009	12,183		8	1,523	1,523	2,411	55
56 Lobby Repairs	2009	12,485		8	1,561	1,561	2,471	56
57 Bathroom repairs	2009	42,802		8	5,350	5,350	6,242	57
58 Door Repairs	2009	3,438		8	430	430	430	58
59 Freezer Repairs	2009	8,666		8	1,083	1,083	1,354	59
60 Fire Pump	2009	6,496		8	812	812	1,286	60
61 Fuses	2009	2,772	277	10	277		508	61
62 Door Hinges	2009	6,408	641	10	641		748	62
63 Boiler	2009	4,300	430	10	430		466	63
64 FRP Installation	2010	3,821		7	45	45	45	64
65 Floor & Ceiling Tile Repairs	2010	8,306		7	99	99	99	65
66 Roof Repairs	2010	3,085		7	37	37	37	66
67 Repair/Replace Sinks & Pipes	2010	16,822		7	601	601	601	67
68 Repair Refrigerator	2010	3,224		7	154	154	154	68
69 Door Repairs	2010	3,367		7	441	441	441	69
70 TOTAL (lines 4 thru 69)		\$ 9,536,396	\$ 35,015		\$ 337,808	\$ 302,793	\$ 3,637,239	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,536,396	\$ 35,015		\$ 337,808	\$ 302,793	\$ 3,637,239	1
2	2010	3,896		7	371	371	371	2
3	2010	5,508		15	214	214	214	3
4	2010	3,463		7	331	331	330	4
5	2010	5,370	224	10	224		224	5
6	2010	10,633	443	10	443		443	6
7	2010	9,065	1,007	3	1,007		1,007	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 9,574,331	\$ 36,689		\$ 340,398	\$ 303,709	\$ 3,639,828	34

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:

1/1/10

Ending:

12/31/10

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	\$ 1,012,966	\$ 16,459	\$ 16,459	\$	5-10 years	\$ 947,702	71
72	Current Year Purchases	29,477	88	899	811	5-10 years	899	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,042,443	\$ 16,547	\$ 17,358	\$ 811		\$ 948,601	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,850,774	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,236	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 357,756	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 304,520	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,588,429	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:

1/1/10

Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

**

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 6,554 Description: Postage Meter \$146; Copier \$5,134; Ice Maker \$1,274

YES NO

(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	\$ 1,830	17
18	Resident Transport	2007 Ford	750.00	7,500	18
19	Resident Transport	2009 Ford	895.00	10,740	19
20	See Attached 14a		#####	30,537	20
21	TOTAL		\$ #####	\$ 50,607	21

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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, 2010

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	2009 Acura	579.00	6,948
Resident Transport	2009 Ford Ecoline	795.00	9,540
Resident Transport	2009 Ford Ecoline	899.00	9,889
Ford Ecoline Lease Cancellation Payment			1,160
Ford Ecoline Lease Termination Fees			3,000
		<hr/> <hr/>	<hr/> <hr/>
		2,273.00	30,537

See Accountants' Compilation Report

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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	450	1,150		1,600
3	Classroom Wages (a)	5,127	15,180		20,307
4	Clinical Wages (b)	4,059	34,155		38,214
5	In-House Trainer Wages (c)	10,965	28,197		39,162
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 20,601	\$ 78,682	\$	\$ 99,283
10	SUM OF line 9, col. 1 and 2 (e)	\$ 99,283			

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	46
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	18
2. From other facilities (f)	
TOTAL TRAINED	64

- (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		visits							5
6	Dental Care	L39, C2	visits				16,698		16,698	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			\$		\$	16,698	\$	16,698	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: 1/1/10

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(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	\$ 255,448	\$ 664,209	1
2	Cash-Patient Deposits	98,229	98,229	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,878,905	2,878,905	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,188	21,199	6
7	Other Prepaid Expenses	36,087	36,087	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule 17a</u>		66,040	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,271,857	\$ 3,764,669	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		8,885,371	14
15	Leasehold Improvements, at Historical Cost	382,106	649,929	15
16	Equipment, at Historical Cost	243,241	1,042,442	16
17	Accumulated Depreciation (book methods)	(352,958)	(4,522,785)	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>		317,349	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 272,389	\$ 6,606,306	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,544,246	\$ 10,370,975	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 178,906	\$ 178,906	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	98,229	98,229	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	314,474	314,474	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		136,965	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>	5,813,891	4,957,580	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,405,500	\$ 5,686,154	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,641,761	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)	\$	\$ 8,641,761	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,405,500	\$ 14,327,915	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,861,254)	\$ (3,956,940)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,544,246	\$ 10,370,975	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

GOLFVIEW DEVELOPMENTAL CENTER, INC.

Provider #0042614

December 31, 2010

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	-	66,040
	<u>-</u>	<u>66,040</u>
Line 23 - Other Long-Term Assets		
Assets Limited as to Use, Required for Replacement Reserves	-	104,298
Mortgage Costs, net	-	213,051
	<u>-</u>	<u>317,349</u>
Line 36 - Other Current Liabilities		
Due to Shareholders	808,000	808,000
Provider Participation Fees Payable	-	-
Due to 3rd-Party Payor	485,096	485,096
Accrued Management Fees	3,664,484	3,664,484
Due to Affiliates	856,311	-
	<u>5,813,891</u>	<u>4,957,580</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,304,562)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,304,562)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	443,308	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)	\$ 443,308	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)	\$ (2,861,254)	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	\$ 9,521,255	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,521,255	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	76,268	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)	\$ 76,268	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>	97,304	28
28a	<u>Miscellaneous Income See Attached Pg 19A</u>	334,387	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 431,691	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,029,214	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,265,351	31
32	Health Care	2,440,265	32
33	General Administration	2,077,880	33
B. Capital Expense			
34	Ownership	1,359,177	34
C. Ancillary Expense			
35	Special Cost Centers	21,149	35
36	Provider Participation Fee	422,084	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,585,906	40
41	Income before Income Taxes (line 30 minus line 40)**	443,308	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 443,308	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, 2010

Schedule 19a

Page 19 - Income Statement

	<u>Operating</u>	<u>After Consolidation</u>
Line 28a - Miscellaneous Income		
Flu Vaccines	1,400	1,400
Miscellaneous Income	158,005	8,255
Vending Machines	1,614	1,614
Commissary Income	9,623	9,623
Extraordinary Inc.	163,745	163,745
	<u>334,387</u>	<u>184,637</u>

See Accountants' Compilation Report

Facility Name & ID Number **Golfview Developmental Center**

0042614

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	1,824	2,080	\$ 60,129	\$ 28.91	1
2	Assistant Director of Nursing	1,701	1,840	41,014	22.29	2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,971	14,461	357,123	24.70	4
5	CNAs & Orderlies					5
6	CNA Trainees	7,030	7,030	56,832	8.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,050	1,252	8,098	6.47	8
9	Activity Director	1,840	2,080	29,303	14.09	9
10	Activity Assistants	6,928	7,714	64,266	8.33	10
11	Social Service Workers	145	145	2,370	16.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,816	2,080	46,436	22.33	14
15	Cook Helpers/Assistants	20,383	21,843	196,474	8.99	15
16	Dishwashers					16
17	Maintenance Workers	3,544	3,982	52,227	13.12	17
18	Housekeepers	25,717	28,200	281,783	9.99	18
19	Laundry	1,781	2,078	28,082	13.51	19
20	Administrator	1,800	2,080	80,885	38.89	20
21	Assistant Administrator					21
22	Other Administrative	1,977	2,170	31,483	14.51	22
23	Office Manager	1,882	2,080	48,774	23.45	23
24	Clerical	3,398	3,653	33,147	9.07	24
25	Vocational Instruction					25
26	Academic Instruction	1,839	2,080	39,270	18.88	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,160	14,006	212,861	15.20	28
29	Resident Services Coordinator	1,757	2,179	43,310	19.88	29
30	Habilitation Aides (DD Homes)	142,960	153,742	1,355,457	8.82	30
31	Medical Records	1,637	1,859	16,105	8.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Exec. Director</u>	1,736	2,080	94,712	45.53	33
34	TOTAL (lines 1 - 33)	258,876	280,714	\$ 3,180,141 *	\$ 11.33	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	177	\$ 8,489	L1, C3	35
36	Medical Director	96	15,993	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,240	L10, C3	39
40	Physical Therapy Consultant	41	2,563	L10A, C3	40
41	Occupational Therapy Consultant	39	1,484	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	102	6,344	L10A, C3	43
44	Activity Consultant	591	41,060	L11, C3	44
45	Social Service Consultant	180	10,850	L12, C3	45
46	Other(specify) <u>Psychologist</u>	43	2,936	L10, C3	46
47	<u>Psychiatrist</u>	40	2,400	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,405	\$ 95,359		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center

Report Period Beginning: 1/1/10

Ending:

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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:

1/1/10Ending: 12/31/10**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 \$2,793
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,862 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. \$ 422,084 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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 47,786 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? 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.