FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0042614

Facility Name: Golfview Developmental Ctr

Address: 9555 W Golfview Rd (Number) | Des Plaines (City) | 60016 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	48,239			48,239	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,239			48,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.90%

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[x]	[ ]	[ ]

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	241,738	41,167	8,652	291,557		291,557		291,557			1
2	Food Purchase		278,308		278,308		278,308		278,308			2
3	Housekeeping	314,817	55,767		370,584		370,584		370,584			3
4	Laundry	27,709	8,175		35,884		35,884		35,884			4
5	Heat and Other Utilities			226,519	226,519		226,519		226,519			5
6	Maintenance	49,915	48,385	140,736	239,036		239,036	(10,045)	228,991			6
7	Other (specify):* Workshop Expense			1,996,594	1,996,594		1,996,594		1,996,594			7
8	TOTAL General Services	634,179	431,802	2,372,501	3,438,482		3,438,482	(10,045)	3,428,437			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,157,470	75,759	12,713	2,245,942		2,245,942		2,245,942			10
10a	Therapy											10a
11	Activities	93,425	23,506	2,016	118,947		118,947		118,947			11
12	Social Services			13,440	13,440		13,440		13,440			12
13	CNA Training	68,689			68,689		68,689		68,689			13
14	Program Transportation					29,836	29,836		29,836			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,319,584	99,265	42,569	2,461,418	29,836	2,491,254		2,491,254			16
	C. General Administration											
17	Administrative	196,473		596,434	792,907		792,907	(596,434)	196,473			17
18	Directors Fees											18
19	Professional Services			87,918	87,918		87,918	20,375	108,293			19
20	Dues, Fees, Subscriptions & Promotions			42,614	42,614		42,614	(18,639)	23,975			20
21	Clerical & General Office Expenses	127,958	52,857	146,128	326,943		326,943		326,943			21
22	Employee Benefits & Payroll Taxes			846,656	846,656		846,656		846,656			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,467	11,467		11,467		11,467			24
25	Other Admin. Staff Transportation			39,781	39,781	(29,836)	9,945		9,945			25
26	Insurance-Prop.Liab.Malpractice			81,946	81,946		81,946	43,700	125,646			26
27	Other (specify):*											27
28	TOTAL General Administration	324,431	52,857	1,852,944	2,230,232	(29,836)	2,200,396	(550,998)	1,649,398			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,278,194	583,924	4,268,014	8,130,132		8,130,132	(561,043)	7,569,089			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 Ctr #0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			53,211	53,211		53,211	311,171	364,382			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,453	50,453		50,453	188,755	239,208			32
33	Real Estate Taxes							283,129	283,129			33
34	Rent-Facility & Grounds			1,088,790	1,088,790		1,088,790	(1,088,790)				34
35	Rent-Equipment & Vehicles			67,388	67,388		67,388	(6,935)	60,453			35
36	Other (specify):*											36
37	TOTAL Ownership			1,259,842	1,259,842		1,259,842	(312,670)	947,172			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			21,578	21,578		21,578		21,578			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			477,259	477,259		477,259		477,259			42
43	Other (specify):* Travel and extertainment			4,290	4,290		4,290	(4,290)				43
44	TOTAL Special Cost Centers			503,127	503,127		503,127	(4,290)	498,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,278,194	583,924	6,030,983	9,893,101		9,893,101	(878,003)	9,015,098			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	63,643	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,290)	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 See Pg. 5A	(657,542)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (598,189)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(279,814)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (279,814)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (878,003)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Golfview Developmental Ctr

ID# 0042614

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Management Fees	$ (596,434)	17	1
2	Dues and Subscriptions	(18,639)	20	2
3	Auto Leasing	(6,935)	35	3
4	Capitalized maintenance	(10,045)	6	4
5	Loan Costs	(25,489)	32	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**	(657,542)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golfview Developmental Ctr **#** 0042614 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(10,045)	0	0	0	0	0	0	0	0	0	0	(10,045)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,045)	0	0	0	0	0	0	0	0	0	0	(10,045)	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	(596,434)	0	0	0	0	0	0	0	0	0	0	(596,434)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,375	0	0	0	0	0	0	0	0	0	20,375	19
20	Fees, Subscriptions & Promotions	(18,639)	0	0	0	0	0	0	0	0	0	0	(18,639)	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	43,700	0	0	0	0	0	0	0	0	0	43,700	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(615,073)	64,075	0	0	0	0	0	0	0	0	0	(550,998)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(625,118)	64,075	0	0	0	0	0	0	0	0	0	(561,043)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golfview Developmental Ctr **#** 0042614 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	63,643	247,528	0	0	0	0	0	0	0	0	0	311,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,489)	214,244	0	0	0	0	0	0	0	0	0	188,755	32
33	Real Estate Taxes	0	283,129	0	0	0	0	0	0	0	0	0	283,129	33
34	Rent-Facility & Grounds	0	(1,088,790)	0	0	0	0	0	0	0	0	0	(1,088,790)	34
35	Rent-Equipment & Vehicles	(6,935)	0	0	0	0	0	0	0	0	0	0	(6,935)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	31,219	(343,889)	0	0	0	0	0	0	0	0	0	(312,670)	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):*	(4,290)	0	0	0	0	0	0	0	0	0	0	(4,290)	43
44	**TOTAL Special Cost Centers**	(4,290)	0	0	0	0	0	0	0	0	0	0	(4,290)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(598,189)	(279,814)	0	0	0	0	0	0	0	0	0	(878,003)	45

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	26	Insurance	$	Golfview realty Partnership	100.00%	$ 43,700	$ 43,700	1
2	V	30	Depreciation		Golfview realty Partnership	100.00%	247,528	247,528	2
3	V	32	Interest Expense		Golfview realty Partnership	100.00%	214,919	214,919	3
4	V	33	Real Estate Taxes		Golfview realty Partnership	100.00%	283,129	283,129	4
5	V	34	Rent Expense	1,088,790	Golfview realty Partnership	100.00%		(1,088,790)	5
6	V	19	Professional Fees		Golfview realty Partnership	100.00%	20,375	20,375	6
7	V	21	Bank Charges		Golfview realty Partnership	100.00%			7
8	V	32	Interest Income		Golfview realty Partnership	100.00%	(675)	(675)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,088,790			$ 808,976	$ * (279,814)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Anthony Miner	President	Admisistrator	100.00	None	70-80	100.00	Salary	$ 112,037	17,1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 112,037		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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Wintrust		x	Working Capital	Interest Only	Various	$ 823,000	$		5.0000	$ 3,956	1
2	PR Mortgage and Inv		x	Mortgage			8,707,928	8,515,723		2.4500	210,763	2
3	Interest Income Offsett		x								(3,006)	3
4	State of Illinois		x	Pre-Bankruptcy DPA Fees							23,339	4
5	PR Mortgage and Inv		x	Mortgage Costs							4,156	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,530,928	$ 8,515,723			$ 239,208	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,530,928	$ 8,515,723			$ 239,208	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** 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.)**

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 149,221	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.)		$ 286,865	2
3. Under or (over) accrual (line 2 minus line 1).		$ 137,644	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 145,486	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.		$ 283,130	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	268,580	8
	2009	273,927	9
	2010	294,425	10
	2011	298,442	11
	2012	290,973	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golfview Developmental Ctr 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-100-013-0000	9555 Golf Road, Des Plaines, IL 6061	$ 262,758.00	$
2.	09-15-100-012-0000	9555 Golf Road, Des Plaines, IL 6061	$ 28,215.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 290,973.00	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential Care	117,000	1977	$ 234,000	1
2					2
3	TOTALS	117,000		$ 234,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1997	1977	$ 8,641,370	$	40	$ 216,034	$ 216,034	$ 3,474,600	4
5			1997		(580,616)		39	(14,888)	(14,888)	(231,525)	5
6			1998		40,292		40	1,007	1,007	15,610	6
7	7		1999	1999	52,495		40	1,312	1,312	19,025	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	4,661	4,661	139,900	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			694	18
19	Security System			2000	2,017		10			1,968	19
20	Telephone Line			2000	7,234		10			7,232	20
21	Security System			2000	2,087		10			2,085	21
22	Specialty Wiring and Oxygen Lines			2001	567,060		10			567,060	22
23	Security System			2001	4,803		10			4,803	23
24	Security System			2001	17,731		10			17,731	24
25	Fire Alarm System			2001	7,583		10			7,583	25
26	Security System			2002	4,402		10			4,402	26
27	Hot Water Tanks			2002	3,142		10			3,142	27
28	Hot Water Pipes			2003	9,150	305	10	305		9,150	28
29	Tile and Wall Covering			2003	4,190	279	10	279		4,190	29
30	Door			2003	3,624	242	10	242		3,623	30
31	Resident Room Repair			2003	5,314	531	10	531		5,312	31
32	2 New Faucets			2003	2,308	231	10	231		2,308	32
33	Floor Repair and Replace			2004	5,966	597	10	597		5,867	33
34	Drywall			2004	6,749	675	10	675		6,637	34
35	Remove Sound Walls			2004	15,133	1,514	10	1,514		14,125	35
36	Dishwasher			2004	2,850	285	10	285		2,684	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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Piping repairs & replace	2005	$ 3,458	$ 346	10	$ 346	$	$ 3,170	37
38	Entry system	2005	3,700	370	10	370		3,330	38
39	Fire damper access hatches	2005	20,122	2,012	10	2,012		16,767	39
40	Floor repair & reaplace	2005	2,290	229	10	229		1,851	40
41	Stairwell construction repairs	2006	120,795	12,079	10	12,079		94,622	41
42	Kitchen improvements	2006	12,735	1,274	10	1,274		9,869	42
43	New dock door	2006	5,982	598	10	598		4,635	43
44	Kitchen Improvements	2006	6,000	600	10	600		4,300	44
45	Guages	2006	2,768	276	10	276		2,075	45
46	Kitchen improvements	2006	5,320	532	10	532		3,911	46
47	Inerior Painting	2007	17,755		5			17,755	47
48	Kitchen improvements	2007	18,996	1,899	10	1,899		12,041	48
49	New door installation	2007	30,313	3,031	10	3,031		20,459	49
50	New fencing	2007	8,076	807	10	807		4,996	50
51	Interior Painting	2008	77,681		9	8,631	8,631	47,471	51
52	Elevator pump repairs	2008	11,875		9	1,319	1,319	7,255	52
53	ceiling valves	2008	2,130	213	10	213		1,065	53
54	Painting	2009	57,865		8	7,233	7,233	32,549	54
55	Parking lot	2009	12,183		8	1,523	1,523	6,980	55
56	Lobby repairs	2009	12,485		8	1,561	1,561	7,154	56
57	Bathroom Repairs	2009	42,802		8	5,350	5,350	22,292	57
58	Door repairs	2009	3,438		8	430	430	1,720	58
59	Freezer repairs	2009	8,666		8	1,083	1,083	4,603	59
60	Fire pump	2009	6,496		8	812	812	3,722	60
61	Fuses	2009	2,772	277	10	277		1,339	61
62	Door hinges	2009	6,408	641	10	641		2,672	62
63	Boiler	2009	4,300	430	10	430		1,756	63
64	FRP installation	2010	3,821		7	546	546	1,683	64
65	Floor and ceiling tile replacement	2010	8,306		7	1,187	1,187	3,660	65
66	Roof repairs	2010	3,085		7	441	441	1,360	66
67	Repair/Replace sink & pipe	2010	16,822		7	2,403	2,403	7,810	67
68	Repair refrigerator	2010	3,224		7	461	461	1,537	68
69	Door repairs	2010	3,367		7	481	481	1,884	69
70	TOTAL (lines 4 thru 69)		$ 9,536,396	$ 30,273		$ 271,860	$ 241,587	$ 4,471,266	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,536,396	$ 30,273		$ 271,860	$ 241,587	$ 4,471,266	1
2	Radiator	2010	3,896		7	557	557	2,041	2
3	Sidewalk	2010	5,508		15	367	367	1,315	3
4	Fire pump	2010	3,463		7	495	495	1,815	4
5	New Carpeting	2010	5,370	537	10	537		1,835	5
6	Replace bathroom stalls	2010	10,633	1,064	10	1,064		3,634	6
7	Keycard system	2010	9,065	2,015	3	2,015		9,066	7
8	Water heater	2011	33,995		6	5,666	5,666	14,637	8
9	New lighting fixtures	2011	25,294		6	4,216	4,216	8,783	9
10	FRP installation & painting	2011	54,329		6	9,055	9,055	24,146	10
11	Roof repairs	2011	36,623		6	6,104	6,104	13,225	11
12	Bathroom stalls and tiling	2011	41,224		6	6,871	6,871	17,177	12
13	Exterior painting	2011	11,023		6	1,837	1,837	3,980	13
14	Dining room painting	2011	7,176		6	1,196	1,196	2,491	14
15	kitchen vacuum	2011	4,487	449	7	449		1,235	15
16	Lighting fixtures - Patient Rooms	2012	4,194		15	280	280	513	16
17	Fire panel	2012	7,451		15	497	497	870	17
18	Control board	2012	3,080		7	440	440	733	18
19	Kitchen exhaust system	2012	4,861		10	486	486	689	19
20	Kitchen compressor	2012	3,580		10	358	358	477	20
21	Hot water pump	2012	4,254		10	425	425	496	21
22	Wall and door painting - Patient Rooms	2012	8,731		5	1,746	1,746	1,892	22
23	Roofing repairs	2013	3,545		15	158	158	158	23
24	Painting - 3rd foor resident rooms	2013	6,500		7				24
25	New walls and flooring -2nd floor resident rooms	2013	5,489		7	784	784	784	25
26	New walls and flooring 3rd floor - resident rooms	2013	5,426		7	711	711	711	26
27	Tile flooring -2nd floor bathroom	2013	9,098		7	1,192	1,192	1,192	27
28	walls and baseboards - 2nd floor resident rooms	2013	18,062		7	2,150	2,150	2,150	28
29	Boiler repairs	2013	3,357		7	360	360	360	29
30	2nd floor Mens bathroom renovation	2013	22,697		7	2,432	2,432	2,432	30
31	Baseboarding - 3rd floor resident rooms	2013	8,079		7	385	385	385	31
32	Weather Stripping	2013	12,174		10	406	406	406	32
33	FRP wall covering - 3rd floor resident rooms	2013	13,984		10	466	466	466	33
34	TOTAL (lines 1 thru 33)		$ 9,933,044	$ 34,338		$ 325,565	$ 291,227	$ 4,591,360	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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,933,044	$ 34,338		$ 325,565	$ 291,227	$ 4,591,360	1
2	HVAC control panel	2013	14,500		10	604	604	604	2
3	Exhaust system	2013	4,435		7	158	158	158	3
4	Exit lighting system	2013	4,366		7	53	53	52	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,956,345	$ 34,338		$ 326,380	$ 292,042	$ 4,592,174	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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,137,980	$ 16,536	$ 31,440	$ 14,904	5-10 Years	$ 1,042,077	71
72	Current Year Purchases	75,958	2,337	6,562	4,225	5-15 Years	6,562	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,213,938	$ 18,873	$ 38,002	$ 19,129		$ 1,048,639	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,404,283	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,211	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 364,382	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 311,171	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,640,813	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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 6,995 Description: Ice maker $1176; Copier $5237; Postage meter $552
    (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	2009 Ford	$ 895.00	$ 10,740	17
18	Resident Transport	2011 Ford	899.00	10,788	18
19	Resident Transport	2011 Ford	895.00	10,740	19
20	See Attached		#######	21,220	20
21	TOTAL		$ #######	$ 53,488	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, 2013

Schedule 14a

Page 14 - Vehicle Rental

Use	Model Year & Make	Monthly Lease Payment	Rental Expense for this period
Administrative	2011 Acura	549.00	3,843
Resident Transport	2011 Ford E354	899.00	10,788
Resident Transport	2011 Ford Daily Rental		526
Administrative	2013 Acura	579.00	3,474
Administrative	2013 Acura - Lease Downpayment		2,589
		2,027.00	21,220.00

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER CNA	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	675	225		900
3	Classroom Wages (a)	1,834	8,910		10,744
4	Clinical Wages (b)	1,283	20,048		21,331
5	In-House Trainer Wages (c)	5,592	30,122		35,714
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 9,384	$ 59,305	$	$ 68,689
10	SUM OF line 9, col. 1 and 2 (e)	$ 68,689			

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	27
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	36

(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

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L39, C3	visits				21,578		21,578	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$ 21,578		$ 21,578	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

STATE OF ILLINOIS

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 811,993	$ 1,225,448	1
2	Cash-Patient Deposits	91,892	91,892	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	988,979	988,979	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,654	64,945	6
7	Other Prepaid Expenses	55,087	55,087	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17a		58,520	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,977,605	$ 2,484,871	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		9,197,071	14
15	Leasehold Improvements, at Historical Cost	386,593	720,246	15
16	Equipment, at Historical Cost	257,991	1,213,937	16
17	Accumulated Depreciation (book methods)	(520,213)	(5,404,480)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17a		450,651	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 124,371	$ 6,411,425	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,101,976	$ 8,896,296	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,179	$ 25,179	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	91,892	91,892	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	356,091	356,091	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		145,486	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17a	4,126,790	3,599,095	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,599,952	$ 4,217,743	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,512,723	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)**	$	$ 8,512,723	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,599,952	$ 12,730,466	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,497,976)	$ (3,834,170)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,101,976	$ 8,896,296	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2013

Schedule 17a

Page 17 - Balance Sheet		**Operating**	**After Consolidation**
Line 9 - Other Current Assets			
	Assets Limited as to Use, Required for Real Estate Taxes & Insurance	-	58,520
Line 23 - Other Long-Term Assets			
	Assets Limited as to Use, Required for Replacement Reserves	-	328,745
	Mortgage Costs, net	-	121,906
		-	450,651
Line 36 - Other Current Liabilities			
	LOC Payable	-	-
	Provider Participation Fees Payable	(38,647)	(38,647)
	Due to 3rd-Party Payor	236,824	236,824
	Accrued Management Fees	3,400,918	3,400,918
	Due to Affiliates	527,695	-
		4,126,790	3,599,095

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Ctr **#** 0042614 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,637,472)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,637,472)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	139,496	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)**	$ 139,496	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)**	$ (2,497,976)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,960,848	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,960,848	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	35,694	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)**	$ 35,694	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	20,833	28
28a	Miscellaneous Income. See Pg 19A	15,222	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,055	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,032,597	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,438,482	31
32	Health Care	2,461,418	32
33	General Administration	2,230,232	33
	B. Capital Expense		
34	Ownership	1,259,842	34
	C. Ancillary Expense		
35	Special Cost Centers	25,868	35
36	Provider Participation Fee	477,259	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,893,101	40
41	**Income before Income Taxes (line 30 minus line 40)****	139,496	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 139,496	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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.**

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

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER, INC.
Provider #0042614
December 31, 2013

Schedule 19a

Page 19 - Income Statement	**Operating**	**After Consolidation**
Line 28a - Miscellaneous Income		
Miscellaneous Income	60	60
Vending Machines	827	827
Flu Vaccines	2,027	2,027
Commissary Income	12,308	12,308
	15,222	15,222

See Accountants' Compilation Report

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,792	2,080	$ 66,675	$ 32.06	1
2	Assistant Director of Nursing	1,821	2,005	51,363	25.62	2
3	Registered Nurses					3
4	Licensed Practical Nurses	12,946	14,081	352,155	25.01	4
5	CNAs & Orderlies	1,799	1,917	15,932	8.31	5
6	CNA Trainees	3,517	3,517	29,365	8.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,712	2,136	26,930	12.61	9
10	Activity Assistants	6,308	6,911	66,495	9.62	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,880	2,080	45,264	21.76	14
15	Cook Helpers/Assistants	19,790	21,475	196,474	9.15	15
16	Dishwashers					16
17	Maintenance Workers	3,375	3,929	49,915	12.70	17
18	Housekeepers	26,872	30,499	314,817	10.32	18
19	Laundry	1,807	2,152	27,709	12.88	19
20	Administrator	1,760	2,080	84,436	40.59	20
21	Assistant Administrator					21
22	Other Administrative	2,661	2,854	46,598	16.33	22
23	Office Manager	1,851	2,040	52,551	25.76	23
24	Clerical	2,854	3,161	28,809	9.11	24
25	Vocational Instruction					25
26	Academic Instruction	1,849	2,080	39,324	18.91	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	12,124	13,859	203,858	14.71	28
29	Resident Services Coordinator	1,896	2,080	45,210	21.74	29
30	Habilitation Aides (DD Homes)	148,633	159,180	1,422,277	8.94	30
31	Medical Records					31
32	Other Health Ca: Executive Director	1,688	2,080	112,037	53.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,935	282,196	$ 3,278,194 *	$ 11.62	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	169	$ 8,652	L1, C3	35
36	Medical Director	48	14,400	L9, C3	36
37	Medical Records Consultant	53	1,850	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,780	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	74	4,683	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	2,016	L11, C3	44
45	Social Service Consultant	192	13,440	L12, C3	45
46	Other(specify) Phychiatrist	12	2,400	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	628	$ 51,221		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	100	$ 112,037
Barbara water	Assistant Administrator	0	84,436
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 196,473

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Edwards Wildman	Legal	$ 7,372
O'Hagan LLC	Legal	2,000
MPRO	Legal	1,020
Carl F. Jenks	Arbitrator	670
Personnel Planners	Human Resources	3,902
Polsinelli Shugart	Legal	48,904
Warady & Davis LLP	Accounting	16,050
Legal Settlement	Settlement	8,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 87,918

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,243
Unemployment Compensation Insurance	75,206
FICA Taxes	252,848
Employee Health Insurance	153,302
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	130,204
Other Employee Benefits	140,853
TOTAL (agree to Schedule V, line 22, col.8)	$ 846,656

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,300
Health Care Worker Background Check	1,641
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Health Care Association	2,121
Cook County	1,182
Illinois Secretary of State	1,078
ID Card Software	0
Miscellaneous Licences and Fees	4,653
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,975

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,467
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,467

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	Amount of Expense Amortized Per Year								
					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 Ctr # 0042614 Report Period Beginning: 1/1/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTHCARE ASSOCIATION**

(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. $ **19,441** Line

(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. $ **714,420**
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? **YES** 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. $ **63,898** 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? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
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.