FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0044149

Facility Name: Greek American Rehab & Care Ctr

Address: 220 North First Street (Number) Wheeling (City) 60090 (Zip Code)

County: Cook

Telephone Number: (847)459-8700 **Fax #** (847)465-9957

HFS ID Number:

Date of Initial License for Current Owners: 04/01/2002

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 06/01/09 to 05/31/10 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) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 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	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	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	18,309		7,974	26,283	8
9	SNF/PED					9
10	ICF	22,298	10,273	462	33,033	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,607	10,273	8,436	59,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.66%

D. How many bed-hold days during this year were paid by the Department?
None (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)
None

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 [X]

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 4/1/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 204 and days of care provided 7,974

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 5/31/2010 Fiscal Year: 5/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	493,015	35,434	6,173	534,622		534,622		534,622			1
2	Food Purchase		340,562		340,562		340,562	(9,220)	331,342			2
3	Housekeeping	427,121	65,355	443	492,919		492,919		492,919			3
4	Laundry	144,649	15,426	7,900	167,975		167,975		167,975			4
5	Heat and Other Utilities			302,386	302,386		302,386	(497)	301,889			5
6	Maintenance	104,983	33	260,555	365,571		365,571	(19,929)	345,642			6
7	Other (specify):*											7
8	TOTAL General Services	1,169,768	456,810	577,457	2,204,035		2,204,035	(29,646)	2,174,389			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	4,474,608	226,318	10,413	4,711,339		4,711,339		4,711,339			10
10a	Therapy	164,826	2,831	675	168,332		168,332		168,332			10a
11	Activities	170,891	7,975	5,593	184,459		184,459		184,459			11
12	Social Services	113,262	94	5,769	119,125		119,125		119,125			12
13	CNA Training											13
14	Program Transportation			40	40		40		40			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,923,587	237,218	33,290	5,194,095		5,194,095		5,194,095			16
	C. General Administration											
17	Administrative	92,713			92,713		92,713		92,713			17
18	Directors Fees											18
19	Professional Services			48,674	48,674		48,674	(500)	48,174			19
20	Dues, Fees, Subscriptions & Promotions			26,504	26,504		26,504	(4,345)	22,159			20
21	Clerical & General Office Expenses	490,778	45,796	187,167	723,741		723,741	(94,047)	629,694			21
22	Employee Benefits & Payroll Taxes			1,123,659	1,123,659		1,123,659		1,123,659			22
23	Inservice Training & Education			4,684	4,684		4,684		4,684			23
24	Travel and Seminar			15,206	15,206		15,206		15,206			24
25	Other Admin. Staff Transportation			1,126	1,126		1,126	(722)	404			25
26	Insurance-Prop.Liab.Malpractice			165,122	165,122		165,122	14,052	179,174			26
27	Other (specify):*											27
28	TOTAL General Administration	583,491	45,796	1,572,142	2,201,429		2,201,429	(85,562)	2,115,867			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,676,846	739,824	2,182,889	9,599,559		9,599,559	(115,208)	9,484,351			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 Greek American Rehab & Care Ctr #0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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			178,817	178,817		178,817	345,313	524,130			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,742	3,742		3,742	851,808	855,550			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,161,519	1,161,519		1,161,519	(1,156,436)	5,083			34
35	Rent-Equipment & Vehicles			7,171	7,171		7,171		7,171			35
36	Other (specify):*							53,809	53,809			36
37	TOTAL Ownership			1,351,249	1,351,249		1,351,249	94,494	1,445,743			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	92,964	271,156	807,366	1,171,486		1,171,486		1,171,486			39
40	Barber and Beauty Shops			1,589	1,589		1,589	(1,589)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,818	115,818		115,818	(4,128)	111,690			42
43	Other (specify):*	42,746		390,488	433,234		433,234	(433,234)				43
44	TOTAL Special Cost Centers	135,710	271,156	1,315,261	1,722,127		1,722,127	(438,951)	1,283,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,812,556	1,010,980	4,849,399	12,672,935		12,672,935	(459,665)	12,213,270			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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.)

	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	(9,175)	02		4
5	Telephone, TV & Radio in Resident Rooms	(497)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,873)	30		9
10	Interest and Other Investment Income	(10,862)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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				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	(81,899)	21		24
25	Fund Raising, Advertising and Promotional	(4,125)	20		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	(482,987)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (612,418)		$	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)	152,753		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 152,753		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (459,665)		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

Greek American Rehab & Care Ctr

ID# 0044149

Report Period Beginning: 06/01/09

Ending: 05/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rebate Income	$ (312)	21	1
2	Marketing Salaries	(42,746)	43	2
3	Bank Charges	(7,325)	21	3
4	Credit Card Fees	(459)	21	4
5	Referral Fees	(3,525)	21	5
6	Meals	(722)	25	6
7	Flowers & Gifts	(220)	20	7
8	Barber & Beauty Expense	(1,589)	40	8
9	Dining Room Rental Income	(45)	02	9
10	Miscellaneous Income	(27)	21	10
11	Various Foundation/Fundraising Expenses	(390,488)	43	11
12	Amortization- Building Company	(562)	36	12
13	Accounting & Audit Fees- Building Company	(8,000)	19	13
14	Licenses & Fees- Building Company	(250)	20	14
15	Bank Charges- Building Company	(94)	21	15
16	Late Fees- Building Company	(1,566)	21	16
17	Excess Provider Fee	(4,128)	42	17
18	Bond Expenses	(500)	21	18
19	Legal Retainer Fees	(500)	19	19
20	Capitalized R&M	(27,157)	06	20
21	Additional R&M	7,228	06	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**	(482,987)		49

Greek American Rehab & Care Ctr

ID# 0044149

Report Period Beginning: 06/01/09

Ending: 05/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab & Care Ctr **#** 0044149 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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													1
2	Food Purchase	(9,220)											(9,220)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(497)											(497)	5
6	Maintenance	(19,929)											(19,929)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(29,646)											(29,646)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(8,500)	8,000										(500)	19
20	Fees, Subscriptions & Promotions	(4,595)	250										(4,345)	20
21	Clerical & General Office Expenses	(95,707)	1,660										(94,047)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(722)											(722)	25
26	Insurance-Prop.Liab.Malpractice		14,052										14,052	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(109,524)	23,962										(85,562)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,170)	23,962										(115,208)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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	(22,873)	368,186										345,313	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10,862)	862,670										851,808	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,156,436)										(1,156,436)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(562)	54,371										53,809	36
37	**TOTAL Ownership**	(34,297)	128,791										94,494	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(1,589)											(1,589)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(4,128)											(4,128)	42
43	Other (specify):*	(433,234)											(433,234)	43
44	**TOTAL Special Cost Centers**	(438,951)											(438,951)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(612,418)	152,753										(459,665)	45

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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
N/A		N/A		Greek American Nursing & Real Estate		Building Co.

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	34	Rental Income	$ 1,156,436	Greek American Nursing & Real Estate	100.00%	$	$ (1,156,436)	1
2	V	32	Interest	534	Greek American Nursing & Real Estate	100.00%	863,204	862,670	2
3	V	36	MIP Insurance		Greek American Nursing & Real Estate	100.00%	53,809	53,809	3
4	V	36	Amortization		Greek American Nursing & Real Estate	100.00%	562	562	4
5	V	19	Accounting & Audit Fees		Greek American Nursing & Real Estate	100.00%	8,000	8,000	5
6	V	30	Depreciation		Greek American Nursing & Real Estate	100.00%	368,186	368,186	6
7	V	26	General Insurance		Greek American Nursing & Real Estate	100.00%	14,052	14,052	7
8	V	20	Licenses & Fees		Greek American Nursing & Real Estate	100.00%	250	250	8
9	V	21	Bank Charges & Late Fees		Greek American Nursing & Real Estate	100.00%	1,660	1,660	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,156,970			$ 1,309,723	$ * 152,753	14

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VII. RELATED PARTIES (continued)

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.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	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	N/A								$		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	$		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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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 [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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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1						$	$		$	1
2										2
3										3
4										4
5										5
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7										7
8										8
9										9
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16										16
17										17
18										18
19										19
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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	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
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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4										4
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8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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1						$	$		$	1
2										2
3										3
4										4
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8										8
9										9
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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1						$	$		$	1
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10										10
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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2										2
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7										7
8										8
9										9
10										10
11										11
12										12
13										13
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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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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3										3
4										4
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6										6
7										7
8										8
9										9
10										10
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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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	
	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	Cambridge Reality Capital		X	Mortgage	$77,989.00	10/1/2001	$ 11,275,000	$ 10,767,805	04/01/2040	7.9000	$ 853,793	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	First Bank		X	Line of Credit							3,742	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$77,989.00		$ 11,275,000	$ 10,767,805			$ 857,535	9
	B. Non-Facility Related*											
10	Interest Income		X								(10,862)	10
11	Int. Income- Building Co.		X								(534)	11
12	Interest Exp- Residual Receipts		X								9,411	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,985)	14
15	TOTALS (line 9+line14)						$ 11,275,000	$ 10,767,805			$ 855,550	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 53,809 **Line #** 36

*** 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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Greek American Rehab & Care Ctr **#** 0044149 **Report Period Beginning:** 06/01/09 **Ending:** 05/31/10

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.	$	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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	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.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

Facility Does Not Pay Real Estate Taxes

	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greek American Rehab & Care Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044149

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greek American Rehab & Care Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044149

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

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

C. **Tax Bills**

Attach a copy of the original 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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,669 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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 [ ] (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: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(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	Facility		1994	$ 425,000	1
2					2
3	TOTALS			$ 425,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2001	58,125		20	2,906	2,906	19,717	9
10	Various			2003	16,264		20	813	813	6,234	10
11	Various			2005	3,121		20	156	156	780	11
12	Various			2006	51,393		20	2,570	2,570	12,130	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

*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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		11,639,080	290,977		290,977		2,327,816	67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			178,817			(178,817)		69
70	TOTAL (lines 4 thru 69)		$ 11,767,983	$ 469,794		$ 297,422	$ (172,372)	$ 2,366,678	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 11,767,983	$ 469,794		$ 297,422	$ (172,372)	$ 2,366,678	1
2	Olympic Carpets - $20,000 Donation Included In Cost	2007	40,000		20	889	889	3,556	2
3	Olympic Carpets - $6,186.88 Donation Included In Cost	2007	11,687		20	260	260	1,040	3
4	Olympic Carpets - $6,158.08 Donation Included In Cost	2007	11,658		20	259	259	1,036	4
5	Olympic Carpets - $10,955.44 Donation Included In Cost	2007	20,955		20	466	466	1,864	5
6	Olympic Carpets - $13,000 Donation Included In Cost	2007	26,000		20	578	578	2,312	6
7	Walls, Flooring, Carpeting, Painting	2007	13,440		20	224	224	896	7
8	Olympic Carpets - $115,806 Donation Included In Cost	2007	195,806		20	6,993	6,993	27,972	8
9	Olympic Carpets - $10,955.44 Donation Included In Cost	2007	20,955		20	349	349	1,396	9
10	Medline	2007	907		20	11	11	44	10
11	Walls, Flooring, Carpeting, Painting	2007	4,200		20	53	53	212	11
12	Walls, Flooring, Carpeting, Painting	2007	6,000		20	25	25	100	12
13	Fire Safety System	2007	4,380		20	219	219	876	13
14	Piping	2007	3,458		20	173	173	692	14
15	Piping	2007	3,110		20	156	156	624	15
16	Carpet - $7,462 Donation	2007	14,622		20	1,915	1,915	5,745	16
17	Remodeling - Painting	2007	20,305		20	846	846	2,538	17
18	Wall Protection	2007	12,145		20	506	506	1,518	18
19	Wall Protection	2007	9,876		20	412	412	1,236	19
20	Wall Protection	2007	2,364		20	89	89	267	20
21	Cove Base - $1,872 Donation	2007	4,368		20	468	468	1,404	21
22	Carpet Labor Charge	2007	300		20	32	32	96	22
23	Carpeting - $580 Donation	2007	1,680		20	160	160	480	23
24	Wall Protection	2007	1,624		20	54	54	162	24
25	Ipc Wall Protection	2007	21,055		20	702	702	2,106	25
26	Cove Base, Carpet - $74,446 Donation	2007	139,446		20	13,281	13,281	39,843	26
27	Ipc Wall Protection	2007	1,692		20	49	49	147	27
28	Locks	2007	1,000		20	117	117	351	28
29	Wood Rods, Holders, Rings	2008	884		20	74	74	222	29
30	Remodeling - Painting	2008	11,590		20	193	193	579	30
31	Carpet, Cove Base - $75,584 Donation	2008	144,584		20	6,885	6,885	20,655	31
32	Ipc Wall Protection	2008	4,639		20	58	58	174	32
33	Exhaust Vent	2008	1,500		20	25	25	75	33
34	TOTAL (lines 1 thru 33)		$ 12,524,213	$ 469,794		$ 333,943	$ (135,851)	$ 2,486,896	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 12,524,213	$ 469,794		$ 333,943	$ (135,851)	$ 2,486,896	1
2	Cove Base, Carpet - $53,446 Donation	2008	78,446		20	934	934	2,802	2
3	Repair Heater	2008	2,599		20	130	130	260	3
4	Rebuild Fireboxes For 2 Rite Boilers	2008	12,000		20	600	600	1,200	4
5	Fix Boiler #1	2008	4,200		20	210	210	420	5
6	Elevator Repairs	2008	3,592		20	180	180	359	6
7	Olympic Carpet- Halls And Rooms	2008	2,860		20	286	286	572	7
8	Beauty Shop	2008	1,880		20	94	94	188	8
9	In Pro Corp- Wall Protectors	2008	11,286		20	846	846	1,692	9
10	In Pro Corp- Wall Protectors	2008	1,749		20	87	87	174	10
11	Fine Dining Room	2008	600		20	60	60	120	11
12	Cover Plate	2008	516		20	52	52	104	12
13	Countertop For Coffee Area	2008	829		20	48	48	96	13
14	Curtains For Fine Dining Room	2008	2,000		20	100	100	200	14
15	Garcc- Clear Plexiglass	2008	827		20	41	41	83	15
16	Curtains For Fine Dining Room	2008	1,500		20	75	75	150	16
17	Shades- Fine Dining Room	2008	722		20	36	36	72	17
18	Medline Industries- Monitor- Security System	2008	6,579		20	329	329	329	18
19	Repairs To Piping System	2009	4,685		20	234	234	469	19
20	Stanely Access Tech- Patio Back Door	2009	2,330		20	78	78	156	20
21	Kleinco Llc- Building Improvements	2009	15,072		20	126	126	252	21
22	Kleinco Llc- Repair And Building Improvements	2009	1,433		20	12	12	24	22
23	Outpatient Therapy Room	2009	5,000		20	125	125	250	23
24	Ar & Jk Construction - Outpatient Therapy Room	2009	4,000		20	67	67	134	24
25	Ar & Jk Construction - Outpatient Therapy Room	2009	5,000		20	42	42	84	25
26	Village Of Wheeling- Outpatient Therapy Room	2009	80		20	1	1	2	26
27	Mirror	2009	550		20	5	5	10	27
28	Intercom	2009	1,200		20	14	14	28	28
29	Ar & Jk Construction - Outpatient Therapy	2009	4,550		20	38	38	76	29
30	Olympic Carpet- Vinyl Base	2009	194		20	2	2	4	30
31	Aluminum Sign	2009	237		20	2	2	4	31
32	Generator Repair	2009	2,888		20	144	144	144	32
33	Piping	2009	12,975		20	649	649	649	33
34	TOTAL (lines 1 thru 33)		$ 12,716,591	$ 469,794		$ 339,591	$ (130,203)	$ 2,498,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12C, Carried Forward		$ 12,716,591	$ 469,794		$ 339,591	$ (130,203)	$ 2,498,002	1
2	Telephone System	2009	27,590		20	1,380	1,380	1,380	2
3	Cabinets Installed At 4Th Floor Nursing Station With Tent - Labo	2009	4,574		20	229	229	229	3
4	Outpatient Therapy Room- Blinds/Wall Protection/Signs/Tent	2009	3,757		20	188	188	188	4
5	Wall Protectors/Kwik Walls	2009	12,428		20	621	621	621	5
6	Painting	2009	6,765		20	338	338	338	6
7	Gift Shop Improvements- Flooring/Painting	2009	7,686		20	384	384	384	7
8	Kitchen Cabinets	2010	5,280		20	264	264	264	8
9	Fire System Repairs	2010	6,014		20	301	301	301	9
10	Monitor	2010	6,532		20	327	327	327	10
11	4Th Floor Renovations- Woodwork/Windows/Nursing Station/Col	2010	150,342		20	7,517	7,517	7,517	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)		$ 12,947,559	$ 469,794		$ 351,139	$ (118,655)	$ 2,509,551	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12D, Carried Forward		$ 12,947,559	$ 469,794		$ 351,139	$ (118,655)	$ 2,509,551	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
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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)		$ 12,947,559	$ 469,794		$ 351,139	$ (118,655)	$ 2,509,551	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information								1
2	Buildings:								2
3	Building- 204 Beds	2001	11,639,080	290,977	40	290,977		2,327,816	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Company Information Continued		$	$		$	$	$	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 11,639,080	$ 290,977		$ 290,977	$	$ 2,327,816	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Related Party Information Continued								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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	$ 1,763,326	$ 77,209	$ 163,174	$ 85,965	10	$ 1,280,156	71
72	Current Year Purchases	32,424		3,094	3,094	10	3,094	72
73	Fully Depreciated Assets	3,169				10	3,169	73
74								74
75	TOTALS	$ 1,798,919	$ 77,209	$ 166,268	$ 89,059		$ 1,286,419	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	Facility	IBS Ford E450	2007	$ 63,300	$	$ 3,768	$ 3,768	5	$ 15,072	76
77	Facility	Jeep Compass	2008	19,700		2,955	2,955	5	8,865	77
78										78
79										79
80	TOTALS			$ 83,000	$	$ 6,723	$ 6,723		$ 23,937	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)	$ 15,254,478	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 547,003	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 524,130	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,873)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,819,906	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.

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Storage Unit				5,083			6
7	TOTAL				$ 5,083 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,171 Description: See Attached Schedule
    (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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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?
   - [ ] YES
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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

(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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 259,325	$		$ 259,325	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	92,964					92,964	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			519,263			519,263	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				263,475		263,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					28,778	7,681		36,459	13
14	TOTAL			$ 92,964		$ 807,366	$ 271,156		$ 1,171,486	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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/10 (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	$ 681,011	$ 712,278	1
2	Cash-Patient Deposits	68,362	68,362	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,230,853	2,230,853	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	483,846	483,846	5
6	Prepaid Insurance	208,436	241,676	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1	1	8
9	Other(specify): See Attached Schedule	478	546,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,672,987	$ 4,283,221	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		425,000	13
14	Buildings, at Historical Cost		11,639,080	14
15	Leasehold Improvements, at Historical Cost	809,400	1,263,001	15
16	Equipment, at Historical Cost	721,331	1,941,677	16
17	Accumulated Depreciation (book methods)	(591,749)	(4,298,471)	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	8,333	25,390	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 947,315	$ 10,995,677	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,620,302	$ 15,278,898	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 684,967	$ 684,968	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	205,597	205,597	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	442,822	442,822	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		70,888	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	8,333	8,333	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,341,719	$ 1,412,608	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,767,805	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		213,235	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,981,040	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,341,719	$ 12,393,648	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,278,583	$ 2,885,250	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,620,302	$ 15,278,898	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,727,785	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,727,789	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,794	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)**	$ 550,794	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,278,583	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,838,456	1
2	Discounts and Allowances for all Levels	(4,055,707)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,782,749	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,928,195	6
7	Oxygen	182	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,928,377	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals	9,175	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	45	16
17	Sale of Drugs	262,194	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,343	19
20	Radiology and X-Ray		20
21	Other Medical Services	37,453	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 329,410	23
	D. Non-Operating Revenue		
24	Contributions	183	24
25	Interest and Other Investment Income***	10,862	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,045	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,172,148	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,172,148	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,223,729	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,204,035	31
32	Health Care	5,194,095	32
33	General Administration	2,201,429	33
	B. Capital Expense		
34	Ownership	1,351,249	34
	C. Ancillary Expense		
35	Special Cost Centers	1,606,309	35
36	Provider Participation Fee	115,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,672,935	40
41	**Income before Income Taxes (line 30 minus line 40)****	550,794	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 550,794	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	6,396	7,949	$ 331,359	$ 41.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	38,305	43,034	1,316,737	30.60	3
4	Licensed Practical Nurses	22,467	24,184	704,747	29.14	4
5	CNAs & Orderlies	145,495	154,837	2,089,216	13.49	5
6	CNA Trainees					6
7	Licensed Therapist	2,142	2,282	92,964	40.74	7
8	Rehab/Therapy Aides	11,031	11,735	164,826	14.05	8
9	Activity Director	1,265	1,356	41,178	30.37	9
10	Activity Assistants	12,022	12,563	129,713	10.32	10
11	Social Service Workers	3,553	3,836	113,262	29.53	11
12	Dietician					12
13	Food Service Supervisor	6,699	7,202	108,059	15.00	13
14	Head Cook	9,571	10,291	154,414	15.00	14
15	Cook Helpers/Assistants	24,311	25,521	230,542	9.03	15
16	Dishwashers					16
17	Maintenance Workers	3,856	4,097	104,983	25.62	17
18	Housekeepers	41,297	43,109	427,121	9.91	18
19	Laundry	16,100	16,841	144,649	8.59	19
20	Administrator	1,004	1,106	92,713	83.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,191	22,839	490,778	21.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,277	1,384	32,549	23.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,392	2,571	42,746	16.63	33
34	TOTAL (lines 1 - 33)	370,374	396,737	$ 6,812,556 *	$ 17.17	34

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	133	$ 6,173	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant	Monthly	3,420	10-03	37
38	Nurse Consultant	Monthly	6,020	10-03	38
39	Pharmacist Consultant	Monthly	973	10-03	39
40	Physical Therapy Consultant	Monthly	675	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	98	5,593	11-03	44
45	Social Service Consultant	74	5,769	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 39,423		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Helen Infantis	Administrator	0.00%	$ 92,713
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,713

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
Duane Morris	Legal	$ 3,356
Pinnacle Consulting	Cust. Satisfaction Consult	3,600
Achieve Accreditation	Accreditation Consulting	11,695
Galetsis & Associates	Accounting	393
Frost, Ruttenberg & Rothblatt	Accounting	29,630
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 48,674

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,285
Unemployment Compensation Insurance	27,633
FICA Taxes	493,541
Employee Health Insurance	492,232
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental & Vision Insurance	2,515
Other Employee Benefits	2,505
Employee Physicals	2,948
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,123,659

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	4,339
Health Care Worker Background Check	
(Indicate # of checks performed 82)	820
Patient Background Checks 183	1,830
Dues, Subscriptions, Memberships	15,170
Advertising	4,125
Less: Public Relations Expense	( )
Non-allowable advertising	(4,125)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,159

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,206
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,206

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
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 Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/09 Ending: 05/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $7,795**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,886** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,175**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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: **Frost, Ruttenberg & Rothblatt, P.C.**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.