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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0044149

Facility Name: Greek American Rehab & CC

Address: 220 North First St (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: 04/01/02

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
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 06/01/15 to 05/31/16 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) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	188	Skilled (SNF)	188	68,808	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	188	TOTALS	188	68,808	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	17,060	9,844	31,239	58,143	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,060	9,844	31,239	58,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.50%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 04/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/02 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 188 and days of care provided 5,297

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 05/31/16 Fiscal Year: 05/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	493,006	64,429	2,262	559,697		559,697		559,697			1
2	Food Purchase		498,244		498,244		498,244	(2,294)	495,950			2
3	Housekeeping	478,261	52,277		530,538		530,538		530,538			3
4	Laundry	89,534	14,065	8,435	112,034		112,034		112,034			4
5	Heat and Other Utilities			308,805	308,805		308,805		308,805			5
6	Maintenance	166,310	15,284	149,162	330,756		330,756	10,255	341,011			6
7	Other (specify):* See Supplemental			68,217	68,217		68,217		68,217			7
8	TOTAL General Services	1,227,111	644,299	536,881	2,408,291		2,408,291	7,961	2,416,252			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	4,174,767	68,854	19,074	4,262,695		4,262,695	(55)	4,262,640			10
10a	Therapy	219,401	742	2,000	222,143		222,143		222,143			10a
11	Activities	155,073	22,017	2,914	180,004		180,004		180,004			11
12	Social Services	117,708	255	3,417	121,380		121,380		121,380			12
13	CNA Training											13
14	Program Transportation	27,076		1,041	28,117		28,117		28,117			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	4,694,025	91,868	42,846	4,828,739		4,828,739	(55)	4,828,684			16
	C. General Administration											
17	Administrative	140,904			140,904		140,904		140,904			17
18	Directors Fees											18
19	Professional Services			258,438	258,438		258,438	(43,004)	215,434			19
20	Dues, Fees, Subscriptions & Promotions			68,833	68,833		68,833	(2,435)	66,398			20
21	Clerical & General Office Expenses	600,693	43,761	537,566	1,182,020		1,182,020	(494,312)	687,708			21
22	Employee Benefits & Payroll Taxes			1,412,805	1,412,805		1,412,805		1,412,805			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,382	12,382		12,382	(1,319)	11,063			24
25	Other Admin. Staff Transportation			8,435	8,435		8,435	(6,859)	1,576			25
26	Insurance-Prop.Liab.Malpractice			161,460	161,460		161,460	27,360	188,820			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	741,597	43,761	2,459,919	3,245,277		3,245,277	(520,569)	2,724,708			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,662,733	779,928	3,039,646	10,482,307		10,482,307	(512,663)	9,969,644			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Greek American Rehab & CC
Medicaid Cost Report
06/01/15 - 05/31/16

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security			68,217	68,217
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	68,217	68,217
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 27 - Other General Administration				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Facility Name & ID Number Greek American Rehab & CC #0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			138,038	138,038		138,038	416,080	554,118			30
31	Amortization of Pre-Op. & Org.							1,833	1,833			31
32	Interest			665	665		665	444,365	445,030			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			756,525	756,525		756,525	(756,525)				34
35	Rent-Equipment & Vehicles			3,049	3,049		3,049		3,049			35
36	Other (specify):* See Supplemental							58,701	58,701			36
37	**TOTAL Ownership**			898,277	898,277		898,277	164,454	1,062,731			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		343,526	813,781	1,157,307		1,157,307		1,157,307			39
40	Barber and Beauty Shops			1,712	1,712		1,712	(1,712)				40
41	Coffee and Gift Shops	30,526	11,956		42,482		42,482	(27,686)	14,796			41
42	Provider Participation Fee			423,241	423,241		423,241		423,241			42
43	Other (specify):* See Supplemental	143,836	2,646	178,892	325,374		325,374	(325,374)				43
44	**TOTAL Special Cost Centers**	174,362	358,128	1,417,626	1,950,116		1,950,116	(354,772)	1,595,344			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,837,095	1,138,056	5,355,549	13,330,700		13,330,700	(702,981)	12,627,719			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Greek American Rehab & CC
Medicaid Cost Report
06/01/15 - 05/31/16

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
Mortgage Insurance Premium			58,701	58,701
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	58,701	58,701
Line 43 - Other Special Cost Centers				
Development	52,336	2,646	168,779	223,761
Marketing	91,500		10,113	101,613
				-
				-
				-
				-
				-
Sub-Total	143,836	2,646	-	325,374

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	(2,294)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,250)	21		5
6	Rented Facility Space	(105)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,428)	32		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	(1,459)	20		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	(404,776)	21		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 Supplemental Schedule	(489,521)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (912,833)		$	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)	209,852		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 209,852		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (702,981)		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' PREPARATION REPORT

Greek American Rehab & CC

ID# 0044149

Report Period Beginning: 06/01/15

Ending: 05/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Snack Shop Revenue	$ (27,686)	41	1
2	Barber and Beauty Revenue (To Expense)	(1,712)	40	2
3	Rebate Revenue	(2,959)	21	3
4	Miscellaneous Revenue	(1,441)	21	4
5	Uniform Revenue	(55)	10	5
6	Marketing	(1,000)	20	6
7	Bank Charges and Credit Card Fees	(31,444)	21	7
8	Gifts	(8,635)	21	8
9	Cable	(10,995)	21	9
10	Meals	(25,243)	21	10
11	Commuting	(6,859)	25	11
12	Capitalized R & M Expensed (Under $2,500)	10,360	06	12
13	Non-Allowable Professional Fees	(55,159)	19	13
14	Development	(223,761)	43	14
15	Marketing	(101,613)	43	15
16	Non-Allowable Seminar	(1,319)	24	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**	(489,521)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab & CC # 0044149 **Report Period Beginning:** 06/01/15 **Ending:** 05/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,294)	0	0	0	0	0	0	0	0	0	0	(2,294)	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	10,255	0	0	0	0	0	0	0	0	0	0	10,255	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	7,961	0	0	0	0	0	0	0	0	0	0	7,961	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	(55)	0	0	0	0	0	0	0	0	0	0	(55)	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**	(55)	0	0	0	0	0	0	0	0	0	0	(55)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(55,159)	12,155	0	0	0	0	0	0	0	0	0	(43,004)	19
20	Fees, Subscriptions & Promotions	(2,459)	24	0	0	0	0	0	0	0	0	0	(2,435)	20
21	Clerical & General Office Expenses	(494,743)	431	0	0	0	0	0	0	0	0	0	(494,312)	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	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	24
25	Other Admin. Staff Transportation	(6,859)	0	0	0	0	0	0	0	0	0	0	(6,859)	25
26	Insurance-Prop.Liab.Malpractice	0	27,360	0	0	0	0	0	0	0	0	0	27,360	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(560,539)	39,970	0	0	0	0	0	0	0	0	0	(520,569)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(552,633)	39,970	0	0	0	0	0	0	0	0	0	(512,663)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab & CC **#** 0044149 **Report Period Beginning:** 06/01/15 **Ending:** 05/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	416,080	0	0	0	0	0	0	0	0	0	416,080	30
31	Amortization of Pre-Op. & Org.	0	1,833	0	0	0	0	0	0	0	0	0	1,833	31
32	Interest	(5,428)	449,793	0	0	0	0	0	0	0	0	0	444,365	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(756,525)	0	0	0	0	0	0	0	0	0	(756,525)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	58,701	0	0	0	0	0	0	0	0	0	58,701	36
37	**TOTAL Ownership**	(5,428)	169,882	0	0	0	0	0	0	0	0	0	164,454	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	(1,712)	0	0	0	0	0	0	0	0	0	0	(1,712)	40
41	Coffee and Gift Shops	(27,686)	0	0	0	0	0	0	0	0	0	0	(27,686)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(325,374)	0	0	0	0	0	0	0	0	0	0	(325,374)	43
44	**TOTAL Special Cost Centers**	(354,772)	0	0	0	0	0	0	0	0	0	0	(354,772)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(912,833)	209,852	0	0	0	0	0	0	0	0	0	(702,981)	45

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	$ 756,525	Hellenic American Care Foundation	100.00%	$	$ (756,525)	1
2	V	32	Interest	196	Hellenic American Care Foundation	100.00%		(196)	2
3	V	19	Professional Fees		Hellenic American Care Foundation	100.00%	12,155	12,155	3
4	V	20	Dues and Subscriptions		Hellenic American Care Foundation	100.00%	24	24	4
5	V	21	Bank Fees		Hellenic American Care Foundation	100.00%	431	431	5
6	V	26	Insurance		Hellenic American Care Foundation	100.00%	27,360	27,360	6
7	V	30	Depreciation		Hellenic American Care Foundation	100.00%	416,080	416,080	7
8	V	31	Amortization		Hellenic American Care Foundation	100.00%	1,833	1,833	8
9	V	32	Interest		Hellenic American Care Foundation	100.00%	449,989	449,989	9
10	V	36	MIP Insurance		Hellenic American Care Foundation	100.00%	58,701	58,701	10
11	V								11
12	V								12
13	V								13
14	Total			$ 756,721			$ 966,573	$ * 209,852	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors				Hellenic American			1
2					Care Foundation	Wheeling, Illinois	Building Company	2
3								3
4	Eleni Bousis				Wheeling Prof.			4
5	Peter Karahalios				Building, LLC	Wheeling, Illinois	Medical Building	5
6	John Davis							6
7	Lisa Palivos				Paterakis Center Ltd	Wheeling, Illinois	Senior Center	7
8	Theodore Pirpiris							8
9	Dino Geroulis							9
10	Paula Tolan - Francis							10
11	Alex Afshari							11
12	Toula Dernis							12
13	Thomas Diamond							13
14	Joanne Giannopoulos							14
15	Peter Kopsaftis							15
16	Demetrious Pirpiris							16
17	George Reveliotis							17
18	Theresa Tzakis							18
19	Mary Kamberos							19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	HUD		X	Mortgage	$47,833.00	09/01/13	$ 10,924,500	$ 10,606,187	04/01/52	4.2200%	$ 449,989	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Other		X								665	6
7												7
8												8
9	TOTAL Facility Related				$47,833.00		$ 10,924,500	$ 10,606,187			$ 450,654	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,428)	10
11	Interest Income - Building		X								(196)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,624)	14
15	TOTALS (line 9+line14)						$ 10,924,500	$ 10,606,187			$ 445,030	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,701 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' PREPARATION 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 & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A - Greek American is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greek American Rehab & CC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044149

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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).

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' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	188			2001	$ 11,639,080	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2001	58,125						9
10	Various			2003	16,264						10
11	Various			2005	3,121						11
12	Various			2006	51,393						12
13	Various			2007	696,321						13
14	Various			2008	137,791						14
15	Various			2009	108,881						15
16	Various			2010	32,439						16
17	Various			2011	17,496						17
18	Various			2012	14,773						18
19	Remove and Install Tile - 2nd, 3rd, 4th Floors - Janitor Closets			2013	5,805						19
20	Electrical Work in Kitchen Panels			2013	3,209						20
21	Seal Coat & Restripe Parking Lot			2013	6,194						21
22	Canopy Light Fixtures			2015	2,620						22
23	Landscapting Brick Hollanstone			2015	5,200						23
24	Parking Lot Lights			2015	28,109						24
25	Conference Room Remodel - Wallpaper, Cove, Paint, and Trim			2016	7,200						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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			$	$		$	$	$	37
38	Hellenic American Care Foundation - Building								38
39									39
40									40
41	Wanderguard System	2008	85,666						41
42	Security Cameras	2008	50,000						42
43	Cove Base, Flooring, Tile, Pipes, Showerhead and Drain	2011	20,415						43
44	Plumbing Replacements	2012	5,000						44
45	Laminate Flooring Installation	2013	11,265						45
46	Install Floor Tile - Housekeeping Director Office and Therapy	2013	11,374						46
47	Tile and Flooring	2012	34,343						47
48	Alpha Wing Guest Bath 1 - Install Tile, Sink, Faucet	2013	9,340						48
49	Alpha Wing Guest Bath 2 - Install Tile, Sink, Faucet	2013	9,340						49
50	Alpha Wing Guest Bath 3 - Install Tile, Sink, Faucet	2013	7,250						50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Financial Statement Depreciation - Operating			138,038		138,038		1,671,484	68
69	Financial Statement Depreciation - Building			416,080		416,080		6,198,389	69
70	TOTAL (lines 4 thru 69)		$ 13,078,014	$ 554,118		$ 554,118	$	$ 7,869,873	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	$ 1,361,761	$	$	$		$	71
72	Current Year Purchases	78,407						72
73	Fully Depreciated Assets	1,225,839						73
74	Disposals							74
75	TOTALS	$ 2,666,007	$	$	$		$	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	Facility	IBS Ford E450	2007	$ 63,300	$	$	$		$	76
77	Facility	Jeep Compas	2008	19,700						77
78										78
79										79
80	TOTALS			$ 83,000	$	$	$		$	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)	$ 16,252,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 554,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 554,118	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,869,873	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.

SEE ACCOUNTANTS' PREPARATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	See Suppl.				0			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 3,049 Description: See Supplemental 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' PREPARATION REPORT

Greek American Rehab & CC
Medicaid Cost Report
06/01/15 - 05/31/16

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Postage Meter	2,093	2,093
Printer	956	956
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	3,049	3,049

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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' PREPARATION REPORT

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	$		$ 211,346	$		$ 211,346	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			74,429			74,429	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			444,907			444,907	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				179,411		179,411	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					164,115		164,115	12
13	Other (specify): See Supplemental	39 - 03				83,099			83,099	13
14	TOTAL			$		$ 813,781	$ 343,526		$ 1,157,307	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' PREPARATION REPORT

Greek American Rehab & CC
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Oxygen		21,701		21,701
Medical Supplies		142,414		142,414
Ambulance			11,471	11,471
Laboratory			19,972	19,972
Respiratory Therapy			22,166	22,166
Equipment Rental			22,294	22,294
Other			7,196	7,196
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
				-
				-
				-
Total	-	164,115	83,099	247,214

STATE OF ILLINOIS

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/16 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,417,921	$ 5,537,118	1
2	Cash-Patient Deposits	12,485	12,485	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,599,263	2,599,263	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	111,229	135,570	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	300	300	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,141,198	$ 8,284,736	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	943,961	1,734,493	15
16	Equipment, at Historical Cost	1,195,638	2,779,506	16
17	Accumulated Depreciation (book methods)	(1,671,484)	(7,869,873)	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 Supplemental Schedule		743,868	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 468,115	$ 9,452,074	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,609,313	$ 17,736,810	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 477,999	$ 477,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	615,704	615,704	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		37,298	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	62,313		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,156,016	$ 1,131,001	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,606,187	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,606,187	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,156,016	$ 11,737,188	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,453,297	$ 5,999,622	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,609,313	$ 17,736,810	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Greek American Rehab & CC
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Deposits	300		300
			-
			-
			-
			-
Sub-Total	300	-	300
Line 23 - Long Term Assets			
Insurance Escow		20,993	20,993
Replacement Reserve Escrow		617,621	617,621
MIP Escrow		39,251	39,251
Loan Fees (Net of Amortization)		66,003	66,003
			-
Sub-Total	-	743,868	743,868
Line 36 - Other Current Liability			
Rent Due From Affiliates	62,313	(62,313)	-
			-
			-
			-
			-
Sub-Total	62,313	(62,313)	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,785,540	1
2	Restatements (describe):		2
3	PY Showed Non-Affiliated Divisions	(2,830,827)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,954,713	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,469	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)**	$ 394,469	17
	B. Transfers (Itemize):		
18	Assets Released From Restrictions	104,115	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 104,115	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,453,297	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	$ 12,795,332	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,795,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,470	6
7	Oxygen	2,150	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,620	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	27,686	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,294	14
15	Telephone, Television and Radio	9,250	15
16	Rental of Facility Space	2,505	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	34,100	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,835	23
	D. Non-Operating Revenue		
24	Contributions	900,186	24
25	Interest and Other Investment Income***	5,428	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 905,614	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	(301,232)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (301,232)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,725,169	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,408,291	31
32	Health Care	4,828,739	32
33	General Administration	3,245,277	33
	B. Capital Expense		
34	Ownership	898,277	34
	C. Ancillary Expense		
35	Special Cost Centers	1,526,875	35
36	Provider Participation Fee	423,241	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,330,700	40
41	**Income before Income Taxes (line 30 minus line 40)****	394,469	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 394,469	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,874,985	44
45	Private Pay - Net Inpatient Revenue	2,647,710	45
46	Medicare - Net Inpatient Revenue	2,698,190	46
47	Other-(specify) Hospice - Net Patient Revenue	414,952	47
48	Other-(specify) Insurance - Net Inpatient Revenue	159,495	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,795,332	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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' PREPARATION REPORT

Greek American Rehab & CC
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Page 19 Supplemental Schedule

Description	Amount	Total
Rebate Revenue	2,959	2,959
Vending Commissions	976	976
Miscellaneous Income	1,441	1,441
Uniform Revenue	55	55
Net Asset Transfers	(306,663)	(306,663)
		-
		-
		-
		-
		-
		-
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		-
		-
		-
Total	(301,232)	(301,232)

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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	1,883	2,080	$ 105,500	$ 50.72	1
2	Assistant Director of Nursing	820	906	33,562	37.04	2
3	Registered Nurses	33,524	37,028	1,140,498	30.80	3
4	Licensed Practical Nurses	19,884	21,962	576,922	26.27	4
5	CNAs & Orderlies	107,641	118,895	1,706,643	14.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,387	11,472	219,401	19.12	8
9	Activity Director	1,883	2,080	42,775	20.56	9
10	Activity Assistants	8,867	9,794	112,298	11.47	10
11	Social Service Workers	5,169	5,709	117,708	20.62	11
12	Dietician					12
13	Food Service Supervisor	3,766	4,160	114,550	27.54	13
14	Head Cook	10,021	11,069	165,376	14.94	14
15	Cook Helpers/Assistants	16,455	18,176	213,080	11.72	15
16	Dishwashers					16
17	Maintenance Workers	6,761	7,468	166,310	22.27	17
18	Housekeepers	35,612	39,335	478,261	12.16	18
19	Laundry	6,909	7,632	89,534	11.73	19
20	Administrator	1,883	2,080	140,904	67.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,144	24,459	600,693	24.56	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	2,019	2,230	38,791	17.40	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	27,544	30,426	774,289	25.45	33
34	TOTAL (lines 1 - 33)	323,172	356,961	$ 6,837,095 *	$ 19.15	34

SEE ACCOUNTANTS' PREPARATION 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		$ 2,262	01 - 03	35
36	Medical Director		14,400	09 - 03	36
37	Medical Records Consultant			10 - 03	37
38	Nurse Consultant		281	10 - 03	38
39	Pharmacist Consultant		15,912	10 - 03	39
40	Physical Therapy Consultant		2,000	10A - 03	40
41	Occupational Therapy Consultant			10A - 03	41
42	Respiratory Therapy Consultant			10A - 03	42
43	Speech Therapy Consultant			10A - 03	43
44	Activity Consultant		2,914	11 - 03	44
45	Social Service Consultant		3,417	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule		2,881		47
48					48
49	TOTAL (lines 35 - 48)		$ 44,067		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

Greek American Rehab & CC
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Nurse Supervisor	10	3,630	4,010	147,769	36.85		
MDS Nurse	10	5,118	5,653	186,487	32.99		
Central Supply Clerk	10	1,483	1,638	31,323	19.12		
Memory Care Director	10	1,890	2,088	77,210	36.98		
Wound Care Nurse	10	2,117	2,338	63,733	27.26		
Recreation Coordinator	10	4,362	4,819	66,329	13.76		
Driver	14	1,578	1,743	27,076	15.53		
Snack Shop	41	2,357	2,604	30,526	11.72		
Business Development	43	1,883	2,080	52,336	25.16		
Marketing	43	3,126	3,453	91,500	26.50		
					-		
					-		
					-		
					-		
Total		27,544	30,426	774,289	25.45		
Contracted Services							
Alzheimers Consultant	10						2,881
Total						-	2,881

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphey	Administrator	0	$ 140,904
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,904

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
Marcum LLP	Accounting	$ 2,000
Frost, Ruttenberg, & Rothblatt	Accounting	35,553
Much Shelist	Legal	436
Louis Palivos, Attorney at Law	Legal	2,500
Victoria Legal + Corporates	Legal	9,064
Gordon Rees Scully Mansuk	Legal	5,000
Duane Morris, LLP	Legal	884
Ability Network, Inc	Data Processing	11,748
Change Healthcare Solutions	Data Processing	250
Medifax-EDI, LLC	Data Processing	400
Blue Star Technology	Data Processing	78,450
See Supplementary Schedule		110,425
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 256,710

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 171,172
Unemployment Compensation Insurance	12,124
FICA Taxes	491,818
Employee Health Insurance	596,436
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	5,714
Vision Insurance	898
Disability Insurance	3,203
Life Insurance	4,729
Employee Physicals	5,359
Other Employee Benefits	121,352
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,412,805

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	21,774
Health Care Worker Background Check	508
(Indicate # of checks performed)	
Patient Background Checks	1,740
Taxes and Licenses	1,160
Dues, Memberships, and Subscriptions	42,675
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 67,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,382
Non-Allowable	(1,319)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,063

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
Surequest Systems	Data Processing	3,415	3,415
American Healthtech	Data Processing	16,320	16,320
Paycomm	Data Processing	22,026	22,026
James Yagnisis	Non-Allowable	5,903	5,903
Employee Benefits Corporation	Human Resource Consultant	3,025	3,025
Thomas Budzik Architecture PC	Non-Allowable	4,289	4,289
Gallagher Bassett Services INC	Non-Allowable	2,607	2,607
Pinnacle Quality Insight	Client Satisfaction Consultant	3,857	3,857
Terrill Consulting Services	Non-Allowable	42,360	42,360
Achieve Accredidation	Accredidation Consulting	6,623	6,623
			-
			-
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			-
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			-
Total		110,425	110,425

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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Much Shelist	Expense Reimbursement	06/01/15	67		67
Victoria Legal + Corporates	BOD Meeting	06/01/15	314		314
Louis Palivos, Attorney at Law	Gerneral Matters	06/11/15	2,500		2,500
Victoria Legal + Corporates	Resident Trusts	06/15/15	8,750		8,750
Gordon Rees Scully Mansuk	Liability Suit	07/22/15	5,000		5,000
Duane Morris, LLP	Auditors Request	09/18/15	612		612
Duane Morris, LLP	Auditors Request	11/17/15	272		272
Much Shelist	Resident Matter	12/01/15	73		73
Much Shelist	IDPH Survey	01/01/16	146		146
Much Shelist	Licensure Matter	02/01/16	75		75
Much Shelist	Resident Matter	04/01/16	75		75
					-
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					-
Total			17,884	-	17,884

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Page 21 Supplemental Schedule - Seminar

Vendor	Session Title	Location	Attendee	Job Description	Amount	Non-Allowable	Allowable
Crisi Prevention Inc.	Dementia Capable Care: Insutrctor Program	Chicago IL	Maria Wallach	Memory Care Director	1,274		1,274
Harper College	36-hour Cert of Completion for Acitivty Dir.	Prospect Hts IL	Mayra Quintana	Recreation Coordinator	399		399
HINSeminars	CMS Focused Surveys	Schaumburg, IL	Ngosa Lumwe	Director of Nursing	199		199
HINSeminars	CMS Focused Surveys	Schaumburg, IL	Miriam Villareal	MDS -LTC	199		199
HINSeminars	CMS Focused Surveys	Schaumburg, IL	Diona Tad-y	MDS - PPS	199		199
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Ngosa Lumbwe	Director of Nursing	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Sue Pollard	Assistant DON	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Marilyn Dannhauer	Restorative Nurse	247		247
INR	Cognition, Diet & Longevity	Skokie IL	John Galenos	Chaplain	81		81
It's Never 2 Late	Personalized Suite Training	Wheeling IL	Activities Dept.	Activities Dept.	1,795		1,795
Illinois Activity Proffessionals	Alzheimer's Disease & Dementia Care	Evanston IL	Brian Baldassara	Activities Director	150		150
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Brian Baldassara	Activities Director	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Joan Thorholm	Admissions Director	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Jeff Hayes	Nurse Liaison	247	247	-
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	France Stamatoukos	Marketing Director	247	247	-
HINSeminars	CMS Focused Surveys	Schaumburg, IL	Maria Wallach	Memory Care Director	199		199
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Barbara Kapple	Social Services Director	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Gertrude Walsh	Asst Soc Services	247		247
Illinois Institute for Continuing Legal Edu	Advising Elderly Clients 2015 Edition	Wheeling IL	Effie Galetsis	CFO	173		173
Fred Pryor Seminars	A Crash Course for the First-Time Manager	Arlington Hts IL	Ngosa Lumbwe	Director of Nursing	99		99
Fred Pryor Seminars	A Crash Course for the First-Time Manager	Arlington Hts IL	Monica Galica	Asst DON	99		99
HINSeminars	CMS Implements a new MDS	Schaumburg, IL	Ngosa Lumbwe	Director of Nursing	199		199
HINSeminars	CMS Implements a new MDS	Schaumburg, IL	Diona Tad-y	MDS Coordinator	199		199
Illinois Dept. of Fincl. & profl Regulation	Professional License Renewal	Chicago IL	Effie Galetsis	CFO	123		123
Illinois CPA Society	Specialized Knowledge for NH Administrators	Rosemont IL	Mark Murphey	Administrator	250		250
Illinois CPA Society	Specialized Knowledge for NH Administrators	Rosemont IL	Effie Galetsis	CFO	205		205
Illinois CPA Society	Not-For-Profit Conference	Rosemont IL	Effie Galetsis	CFO	500		500
Illinois CPA Society	Healthcare Compliance and Fraud	Rosemont IL	Paula Francis	Legal Counsel	250		250
Life Services Network	Operations Conference	Lisle IL	Mark Murphey	Administrator	135		135
Life Services Network	Operations Conference	Lisle IL	Mordechai Finkel	HR Director	135		135
EB First Illinois HFM	First Illinois HFMA Fall Summit	Naperville IL	Effie Galetsis	CFO	253		253
PESI	Illinois Elder Law Seminar-2016	Arlington Hts IL	Effie Galetsis	CFO	200		200
PESI	Illinois Elder Law Seminar-2016	Arlington Hts IL	Wendy Campos	Case Manager	200		200
HINSeminars	CMS Focused Surveys	Schaumburg, IL	Mark Murphey	Administrator	199		199
Life Services Network	Authorized Electronic Monitoring Act in LTC	Wheeling IL	Mark Murphey	Administrator	99		99
Skillpath National	OSHA Compliance & Workplace Safety	Arlington Hts IL	Mark Murphey	Administrator	72		72
Skillpath National	OSHA Compliance & Workplace Safety	Arlington Hts IL	Mordechai Finkel	HR Director	72		72
Skillpath National	OSHA Compliance & Workplace Safety	Arlington Hts IL	Amira Ibrahimovice	HSKP Director	72		72
Skillpath National	OSHA Compliance & Workplace Safety	Arlington Hts IL	Russ Staufenbiel	Maintenance Director	72		72
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Effie Galetsis	CFO	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Mark Murphey	Administrator	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Nancy Wener	ood Services Coordinato	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Mordechai Finkel	HR Director	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Amira Ibrahimovice	HSKP Director	247		247
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Pat Gerbanas	Bus. Devl. Director	247	247	-
NIU	LeadingAge Illinois Annual Meeting & Exhibit.	Schaumburg, IL	Stuart Ruffin	Food Serv. Director	247	247	-
Armed Intruder	CHUG Conference on Active Shooter	Oak Lawn IL	Pat Gerbanas	Bus. Devl. Director	331	331	-
							-
Total					12,382	1,319	11,063

Facility Name & ID Number Greek American Rehab & CC # 0044149 Report Period Beginning: 06/01/15 Ending: 05/31/16

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. **Leading Age**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,812** Line **10 - 02**

(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. $ **423,241**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION 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. $ ____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,294**

(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. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
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**
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: **Plante & Moran, PLLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees