FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 Ct

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: Christopher S. Joos **Telephone Number:** (614) 222 - 9040
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 06/01/16 to 05/31/17 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) Christopher S. Joos, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 250 South High Street, Suite 100 Columbus, OH 43215
(Telephone) (614) 222 - 9040 Fax # (248) 233 - 8811

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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	68,620	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	68,620	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	38,301	9,491	6,402	54,194	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,301	9,491	6,402	54,194	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.98%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 5,887

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 05/31/17 Fiscal Year: 05/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	550,067	118,426		668,493		668,493		668,493			1
2	Food Purchase		413,574		413,574		413,574	(2,791)	410,783			2
3	Housekeeping	427,177	43,574		470,751		470,751		470,751			3
4	Laundry	122,221	8,477	7,800	138,498		138,498		138,498			4
5	Heat and Other Utilities			283,173	283,173		283,173		283,173			5
6	Maintenance	150,449	34,621	155,047	340,117		340,117	7	340,124			6
7	Other (specify):* See Supplemental			67,036	67,036		67,036		67,036			7
8	TOTAL General Services	1,249,914	618,672	513,056	2,381,642		2,381,642	(2,784)	2,378,858			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	4,311,816	79,740	17,496	4,409,052		4,409,052		4,409,052			10
10a	Therapy	193,721	1,550		195,271		195,271		195,271			10a
11	Activities	317,291	7,767	26,050	351,108		351,108		351,108			11
12	Social Services	141,808	1,203	2,992	146,003		146,003		146,003			12
13	CNA Training											13
14	Program Transportation	6,292		1,514	7,806		7,806		7,806			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	4,970,928	90,260	62,452	5,123,640		5,123,640		5,123,640			16
	C. General Administration											
17	Administrative	162,573			162,573		162,573		162,573			17
18	Directors Fees											18
19	Professional Services			253,002	253,002		253,002	(6,250)	246,752			19
20	Dues, Fees, Subscriptions & Promotions			35,093	35,093		35,093		35,093			20
21	Clerical & General Office Expenses	548,768	36,246	405,627	990,641		990,641	(388,402)	602,239			21
22	Employee Benefits & Payroll Taxes			1,485,871	1,485,871		1,485,871		1,485,871			22
23	Inservice Training & Education											23
24	Travel and Seminar			29,744	29,744		29,744	(1,911)	27,833			24
25	Other Admin. Staff Transportation			6,239	6,239		6,239		6,239			25
26	Insurance-Prop.Liab.Malpractice			191,754	191,754		191,754	20,864	212,618			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	711,341	36,246	2,407,330	3,154,917		3,154,917	(375,699)	2,779,218			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,932,183	745,178	2,982,838	10,660,199		10,660,199	(378,483)	10,281,716			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 Care Ct
Medicaid Cost Report
06/01/16 - 05/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security			67,036	67,036
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	67,036	67,036
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 27 - Other General Administration				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Greek American Rehab Care Ct
Medicaid Cost Report
06/01/16 - 05/31/17

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Mark Murphey	Various	Various	Various	4,953			4,953
Margarita Denekos	Various	Various	Various	323			323
Mordechai Finkel	Various	Various	Various	154			154
Paula Francis	Various	Various	Various	119			119
Stuart Ruffin	Various	Various	Various	53			53
Ngosa Lumbwe	Various	Various	Various	97			97
Maryl Robinson	Various	Various	Various	70			70
Other	Various	Various	Various	471			471
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				6,239	-	-	6,239

Facility Name & ID Number Greek American Rehab Care Ct #0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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			154,814	154,814		154,814	391,357	546,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							414,849	414,849			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			728,388	728,388		728,388	(728,388)				34
35	Rent-Equipment & Vehicles			6,461	6,461		6,461		6,461			35
36	Other (specify):* See Supplemental							58,008	58,008			36
37	TOTAL Ownership			889,663	889,663		889,663	135,826	1,025,489			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		377,264	874,224	1,251,488		1,251,488		1,251,488			39
40	Barber and Beauty Shops			1,268	1,268		1,268		1,268			40
41	Coffee and Gift Shops	34,540	9,628		44,168		44,168	(19,799)	24,369			41
42	Provider Participation Fee			394,340	394,340		394,340		394,340			42
43	Other (specify):* See Supplemental	289,899		152,785	442,684		442,684	(442,684)				43
44	TOTAL Special Cost Centers	324,439	386,892	1,422,617	2,133,948		2,133,948	(462,483)	1,671,465			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,256,622	1,132,070	5,295,118	13,683,810		13,683,810	(705,140)	12,978,670			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 Care Ct
Medicaid Cost Report
06/01/16 - 05/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
Hellenic American Care Foundation				-
Mortgage Insurance Premium			58,008	58,008
				-
				-
				-
				-
				-
Sub-Total	-	-	58,008	58,008
Line 43 - Other Special Cost Centers				
Marketing	200,935		152,785	353,720
Development	88,964			88,964
				-
				-
				-
				-
				-
Sub-Total	289,899	-	152,785	442,684

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	(2,791)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,820)	21		5
6	Rented Facility Space	(2,525)	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	(1,960)	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	(7,487)	21		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	(328,666)	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 See Supplemental	(526,143)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (877,392)		$	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)	172,252		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 172,252		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (705,140)		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 Care Ct

ID# 0044149

Report Period Beginning: 06/01/16

Ending: 05/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee and Gift Shop Revenue	$ (19,799)	41	1
2	Miscellaneous Revenue	(7,793)	21	2
3	Postage / Copy Revenue	(3,410)	21	3
4	Rebate Revenue	(2,659)	21	4
5	Capitalized Assets Expensed < $2,500	2,532	06	5
6	Legal Fees	(6,250)	19	6
7	Cable	(16,504)	21	7
8	Bank Charges	(6,376)	21	8
9	Credit Card Fees	(3,767)	21	9
10	Gifts	(3,920)	21	10
11	Seminar Expense	(1,911)	24	11
12	Marketing	(353,720)	43	12
13	Development	(88,964)	43	13
14				14
15	Hellenic American Care Foundation			15
16	Professional Fees	(11,337)	19	16
17	Bank Fees	(432)	21	17
18	Amortization	(1,833)	31	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**	(526,143)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 **Report Period Beginning:** 06/01/16 **Ending:** 05/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,791)	0	0	0	0	0	0	0	0	0	0	(2,791)	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	7	0	0	0	0	0	0	0	0	0	0	7	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,784)	0	0	0	0	0	0	0	0	0	0	(2,784)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	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	(17,587)	11,337	0	0	0	0	0	0	0	0	0	(6,250)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(388,834)	432	0	0	0	0	0	0	0	0	0	(388,402)	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	(1,911)	0	0	0	0	0	0	0	0	0	0	(1,911)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	20,864	0	0	0	0	0	0	0	0	0	20,864	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(408,332)	32,633	0	0	0	0	0	0	0	0	0	(375,699)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(411,116)	32,633	0	0	0	0	0	0	0	0	0	(378,483)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab Care Ct **#** 0044149 **Report Period Beginning:** 06/01/16 **Ending:** 05/31/17

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	391,357	0	0	0	0	0	0	0	0	0	391,357	30
31	Amortization of Pre-Op. & Org.	(1,833)	1,833	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,960)	416,809	0	0	0	0	0	0	0	0	0	414,849	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(728,388)	0	0	0	0	0	0	0	0	0	(728,388)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	58,008	0	0	0	0	0	0	0	0	0	58,008	36
37	**TOTAL Ownership**	(3,793)	139,619	0	0	0	0	0	0	0	0	0	135,826	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(19,799)	0	0	0	0	0	0	0	0	0	0	(19,799)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(442,684)	0	0	0	0	0	0	0	0	0	0	(442,684)	43
44	**TOTAL Special Cost Centers**	(462,483)	0	0	0	0	0	0	0	0	0	0	(462,483)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(877,392)	172,252	0	0	0	0	0	0	0	0	0	(705,140)	45

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 728,388	Hellenic American Care Foundation	100.00%	$	$ (728,388)	1
2	V	32	Interest	184	Hellenic American Care Foundation	100.00%		(184)	2
3	V	19	Professional Fees		Hellenic American Care Foundation	100.00%	11,337	11,337	3
4	V	20	Dues and Subscriptions		Hellenic American Care Foundation	100.00%			4
5	V	21	Bank Fees		Hellenic American Care Foundation	100.00%	432	432	5
6	V	26	Insurance		Hellenic American Care Foundation	100.00%	20,864	20,864	6
7	V	30	Depreciation		Hellenic American Care Foundation	100.00%	391,357	391,357	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%	416,993	416,993	9
10	V	36	Mortgage Insurance		Hellenic American Care Foundation	100.00%	58,008	58,008	10
11	V								11
12	V								12
13	V								13
14	Total			$ 728,572			$ 900,824	$ * 172,252	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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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							1
2								2
3	Eleni Bousis				Hellenic American			3
4	Peter G. Karahalios, JD				Care Foundation	Wheeling, Illinois	Building Company	4
5	Lisa Palivos, MD							5
6	Alex Afshari				Wheeling Professional			6
7	Paula A Tolan-Francis, JD				Building, LLC	Wheeling, Illinois	Medical Building	7
8	Dino Geroulis							8
9	Nicholas Pishos				Paterakis Center, Ltd.	Wheeling, Illinois	Senior Center	9
10	Toula Dernis							10
11	Thomas Diamond							11
12	Robert S Fakouri, JD							12
13	Peter Kopsaftis							13
14	Nicholas A Lalios, DPM							14
15	Demetrios Pirpiris							15
16	Chadwick Pradromos, MD							16
17	George Reveliotis, JD							17
18	Theresa Tzakis							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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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									$		1
2	N/A										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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 10,470,702	04/01/52	4.22%	$ 416,993	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Other		X									6
7												7
8												8
9	TOTAL Facility Related				$47,833.00		$ 10,924,500	$ 10,470,702			$ 416,993	9
	B. Non-Facility Related*											
10	Interest Income										(1,960)	10
11	Interest Income - Building										(184)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,144)	14
15	TOTALS (line 9+line14)						$ 10,924,500	$ 10,470,702			$ 414,849	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,008 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.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greek American Rehab Care Ct COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044149

CONTACT PERSON REGARDING THIS REPORT Christopher S. Joos

TELEPHONE (614) 222 - 9040 FAX #: (248) 233 - 8811

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

N/A - Greek American Rehab and Care Center, Inc. is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	Various			2013	15,208						19
20	Canopy - Light Fixtures			2015	2,620						20
21	Landscaping - Brick Hollanstone			2015	5,200						21
22	Parking Lot - Lights			2015	28,109						22
23	Conference Room Remodel - Wallpaper, Cove, Paint, and Trim			2016	7,200						23
24	Elevator Shaft - Pit Ladder Repacement			2016	5,910						24
25	Walk in Cooler - Shelving			2016	6,395						25
26	Boiler Room - Heating Pump			2017	5,364						26
27	Boiler Room - New Electrical Subpanel for Generator (Expensed Pg. 5)			2017							27
28	3rd Floor Dining Room - Steam Table Electical Wiring (Expensed Pg. 5)			2017							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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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								38
39									39
40									40
41	Various	2008	135,666						41
42	Various	2011	20,415						42
43	Various	2012	39,343						43
44	Various	2013	48,569						44
45	Parking Lot - Paving	2016	66,261						45
46	Boiler Room - Hot Water Tank	2017	70,060						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									67
68	Depreciation - Greek American Rehab and Care Center, Inc.			154,814		154,814		1,826,298	68
69	Depreciation - Hellenic American Care Foundation			391,357		391,357		6,589,746	69
70	TOTAL (lines 4 thru 69)		$ 13,232,004	$ 546,171		$ 546,171	$	$ 8,416,044	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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 2,666,007	$	$	$		$	71
72	Current Year Purchases	79,062						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	$ 2,745,069	$	$	$		$	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)	$ 16,485,073	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 546,171	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 546,171	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)	$ 8,416,044	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 Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,461 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 Care Ct
Medicaid Cost Report
06/01/16 - 05/31/17

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
N/A		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Copier / Printer	6,461	6,461
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	6,461	6,461

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$		$ 248,601	$		$ 248,601	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			103,244			103,244	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			455,446			455,446	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				252,162		252,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					125,102		125,102	12
13	Other (specify): See Supplemental	39 - 03				66,933			66,933	13
14	TOTAL			$		$ 874,224	$ 377,264		$ 1,251,488	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 Care Ct
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		125,102		125,102
Ambulance			14,849	14,849
Laboratory			18,782	18,782
Equipment Rental			22,009	22,009
Respiratory Therapy			1,105	1,105
Other			10,188	10,188
				-
				-
				-
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				-
				-
Total	-	125,102	66,933	192,035

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/17 (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	$ 2,614,885	$ 2,814,529	1
2	Cash-Patient Deposits	152,865	152,865	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 495,064)	2,540,797	2,540,797	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	85,893	109,941	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)**	$ 5,394,740	$ 5,618,432	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	1,870,814	15
16	Equipment, at Historical Cost	1,255,587	2,839,455	16
17	Accumulated Depreciation (book methods)	(1,826,298)	(8,416,044)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,009,592	2,009,592	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		724,592	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,382,842	$ 11,092,489	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,777,582	$ 16,710,921	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 632,902	$ 632,902	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	145,639	145,639	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	728,233	728,233	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,448	39,343	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	111,481	111,481	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,624,703	$ 1,657,598	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,470,702	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)**	$	$ 10,470,702	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,624,703	$ 12,128,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,152,879	$ 4,582,621	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,777,582	$ 16,710,921	48

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***(See instructions.)**

Greek American Rehab Care Ct
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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 Escrow		20,154	20,154
Replacement Reserve Escrow		601,474	601,474
MIP Escrow		38,794	38,794
Loan Fees (Net of Amortization)		64,170	64,170
			-
Sub-Total	-	724,592	724,592
Line 36 - Other Current Liability			
Resident Deposits	89,349		89,349
Unearned Revenue	22,132		22,132
			-
			-
			-
Sub-Total	111,481	-	111,481
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,453,297	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,453,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	443,561	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 443,561	17
	B. Transfers (Itemize):		
18	**Cumulative Net Asset Transfers - Intercompany**	(1,743,979)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,743,979)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,152,879	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	$ 13,256,127	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,256,127	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,713	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 226,713	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	19,799	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,791	14
15	Telephone, Television and Radio	7,820	15
16	Rental of Facility Space	2,525	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 32,935	23
	D. Non-Operating Revenue		
24	Contributions	595,774	24
25	Interest and Other Investment Income***	1,960	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 597,734	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,862	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,862	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,127,371	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,381,642	31
32	Health Care	5,123,640	32
33	General Administration	3,154,917	33
	B. Capital Expense		
34	Ownership	889,663	34
	C. Ancillary Expense		
35	Special Cost Centers	1,739,608	35
36	Provider Participation Fee	394,340	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,683,810	40
41	**Income before Income Taxes (line 30 minus line 40)****	443,561	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 443,561	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,996,271	44
45	Private Pay - Net Inpatient Revenue	2,227,958	45
46	Medicare - Net Inpatient Revenue	3,453,189	46
47	Other-(specify) Insurance - Net Inpatient Revenue	90,102	47
48	Other-(specify) Hospice - Net Inpatient Revenue	488,607	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,256,127	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

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Page 19 Supplemental Schedule

Description	Amount	Total
Miscellaneous Revenue	7,793	7,793
Postage / Copy Revenue	3,410	3,410
Rebate Revenue	2,659	2,659
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Total	13,862	13,862

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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	1,794	2,080	$ 108,251	$ 52.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	43,631	46,768	1,578,910	33.76	3
4	Licensed Practical Nurses	19,003	20,707	561,737	27.13	4
5	CNAs & Orderlies	121,901	129,027	1,968,069	15.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,911	10,529	193,721	18.40	8
9	Activity Director	4,088	4,405	90,041	20.44	9
10	Activity Assistants	18,390	19,402	227,250	11.71	10
11	Social Service Workers	5,279	5,667	141,808	25.02	11
12	Dietician	2,201	2,362	58,318	24.69	12
13	Food Service Supervisor	2,016	2,160	67,484	31.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,012	31,185	424,265	13.60	15
16	Dishwashers					16
17	Maintenance Workers	5,668	6,094	150,449	24.69	17
18	Housekeepers	31,240	33,799	427,177	12.64	18
19	Laundry	8,865	9,794	122,221	12.48	19
20	Administrator	1,832	2,160	162,573	75.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,219	20,281	548,768	27.06	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	2,058	2,180	50,479	23.16	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	15,555	16,428	375,101	22.83	33
34	TOTAL (lines 1 - 33)	341,663	365,028	$ 7,256,622 *	$ 19.88	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		$		35
36	Medical Director		14,400	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,584	10 - 03	38
39	Pharmacist Consultant		15,912	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,224	11 - 03	44
45	Social Service Consultant		2,992	12 - 03	45
46	Other(specify) See Supplemental		5,480		46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 43,592		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

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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Central Supply Clerk	10	2,983	3,155	44,370	14.06		
Bus Driver	14	516	545	6,292	11.54		
Snack Shop	41	2,677	2,737	34,540	12.62		
Marketing	43	6,484	6,903	200,935	29.11		
Development	43	2,895	3,088	88,964	28.81		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		15,555	16,428	375,101	22.83		
Contracted Services							
Alzheimers Consultant	11						5,480
Total						-	5,480

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphey	Administrator	0	$ 162,573
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 162,573

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 / Audit	$ 4,000
Plante & Moran, PLLC	Accounting / Audit	57,100
Smartlinx Solutions, LLC	Payroll Processing	36,430
Blue Star Technology	IT / Server Consultant	66,000
American Healthtech	Data Processing	20,497
Change Healthcare Solutions	Data Processing	600
Ability Network, Inc.	Data Processing	11,958
Personnel Planners, Inc.	Unemployment Consultant	1,800
Employee Benefits Corporation	HR Consultant	1,820
Gallagher Basset Services, Inc.	Ins. / Risk Management	4,750
Southeastern Employer Services	HR Consultant	600
See Supplemental Schedule		47,447
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 253,002

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 166,918
Unemployment Compensation Insurance	7,937
FICA Taxes	508,211
Employee Health Insurance	755,203
Employee Meals	14,073
Illinois Municipal Retirement Fund (IMRF)*	
403(B) Plan	
Dental Insurance	5,702
Vision Insurance	1,240
Disability Insurance	6,667
Life Insurance	5,803
Employee Physicals	5,733
Other Employee Benefits	8,384
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,485,871

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	$ 1,990
Advertising: Employee Recruitment	13,113
Health Care Worker Background Check	
(Indicate # of checks performed)	1,222
Patient Background Checks	1,910
Licenses	261
Dues and Subscriptions	8,817
Accredidation Fees	7,780
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,093

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	29,744
Non-Allowable	(1,911)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,833

* Attach copy of IMRF notifications
**See instructions.

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
Much Shelist	Legal	8,733	8,733
Duane Morris, LLP	Legal	7,679	7,679
Jackson Lewis, PC	Legal	13,428	13,428
Stone, McGuire & Siegel, PC	Legal	3,606	3,606
Achieve Accredidation	Accredidation Consultant	10,096	10,096
Pinnacle Quality Insight	Client Satisfaction Consultant	3,905	3,905
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			-
Total		47,447	47,447

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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Much Shelist	Resident Matter	06/30/16	638	-	638
Much Shelist	Line of Credit Refinancing	07/31/16	6,250	6,250	-
Much Shelist	Resident Matter	08/31/16	1,845	-	1,845
Duane Morris, LLP	Audit Confirmation / Resident Matter	07/31/16	1,197	-	1,197
Duane Morris, LLP	Audit Confirmation	10/31/16	278	-	278
Jackson Lewis, PC	Resident Matter	10/31/16	3,548	-	3,548
Jackson Lewis, PC	Resident Matter	11/30/16	5,429	-	5,429
Jackson Lewis, PC	Resident Matter	11/30/16	771	-	771
Jackson Lewis, PC	Resident Matter	12/31/16	167	-	167
Duane Morris, LLP	Resident Matter	01/31/17	2,371	-	2,371
Duane Morris, LLP	Resident Matter	01/31/17	2,371	-	2,371
Jackson Lewis, PC	Resident Matter	01/31/17	29	-	29
Jackson Lewis, PC	Resident Matter	02/28/17	338	-	338
Duane Morris, LLP	Resident Matter	02/28/17	(607)	-	(607)
Duane Morris, LLP	Resident Matter	03/31/17	1,430	-	1,430
Jackson Lewis, PC	Resident Matter	03/31/17	733	-	733
Jackson Lewis, PC	Resident Matter	04/30/17	2,385	-	2,385
Stone, McGuire & Siegel, PC	Compliance Plan	03/31/17	1,200	-	1,200
Jackson Lewis, PC	Resident Matter	03/31/17	29	-	29
Stone, McGuire & Siegel, PC	Compliance Plan	04/30/17	1,200	-	1,200
Stone, McGuire & Siegel, PC	Compliance Plan	05/31/17	1,207	-	1,207
Duane Morris, LLP	Resident Matter	05/31/17	639	-	639
					-
					-
					-
					-
					-
					-
					-
					-
Total			33,446	6,250	27,196

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Page 21 Supplemental Schedule - Seminar

Vendor	Session Title	Location	Attendee	Position	Amount	Non-Allowable	Allowable
HINSeminars	Medicare Forum	Schamuburg, IL	Marilyn Dannhauer	Restorative Nurse	199		199
HINSeminars	Medicare Forum	Schamuburg, IL	Ngosa Lumbwe	Director of Nursing	199		199
Leading Age	Workforce Summit	Lisle IL	Ngosa Lumwe	Director of Nursing	117		117
HINSeminars	New MDS/RAI Users Manual	Schaumburg, IL	Marilyn Dannhauer	Restorative Nurse	199		199
HINSeminars	New MDS/RAI Users Manual	Schaumburg, IL	Diona Tad-y	MDS - PPS	199		199
HINSeminars	New MDS/RAI Users Manual	Schaumburg, IL	Miriam Villareal	MDS - PPS	199		199
HINSeminars	New Requirements of Participation	Schaumburg, IL	Ngosa Lumbwe	Director of Nursing	199		199
Various CNAs	Food Handlers Certification	Online		C N A	70		70
Various CNAs	Food Handlers Certification	Online		C N A	50		50
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Ngosa LUmbwe	Director of Nursing	349		349
Estella Cruz	Food Handlers Certification	Online	Estella Cruz	C N A	10		10
CPI	Dementia Care Inst. Program	Chicago IL	Lindsey Freling	Memory Care Dir	1,779		1,779
Harper Quyikpay	Certificate Program	Prospect Hts, IL	Vasiliki Straitopoulos	Activities Dir	399		399
Chicagoland Activities Professionals Ass	Aroma Techniques Hand Massage	Park Ridge, IL	Vasiliki Straitopoulos	Activities Dir	10		10
Various activity staff	Food Handlers Certification	Online		Activity Staff	20		20
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Vasiliki Straitopoulos	Activities Dir	349		349
CPI	Foundation Course Partcipant Wkbk	Chicago IL	Maria Wallach	Memory Care Dir	820		820
Northshore Univ Health System	DementiaTraining	Glencoe, IL	Lindsey Freling	Memory Care Dir	25		25
CPI	Dementia Capable Care Wrkbk	Chicago IL	Lindsey Freling	Memory Care Dir	689		689
Mayra Quintana	Food Handlers Certification	online	Mayra Quintana	Recreation Coord.	10		10
HINSeminars	New Requirements of Participation	Schaumburg, IL	Lindsey Freling	Memory Care Dir	199		199
Caregiving.com	CCC & CDCS Certification	Chicago IL	Lindsey Freling	Memory Care Dir	500		500
Caregiving.com	CCC & CDCS Certification	Chicago IL	Lindsey Freling	Memory Care Dir	500		500
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Lindsey Freling	Memory Care Dir	349		349
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Mayra Quintana	Recreation Coord.	349		349
ACMA	ACMA Illinois Conference	Rosemont IL	Frances Stamatoukos	Marketing Dir	950	950	-
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Frances Stamatoukos	Marketing Dir	349	349	-
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Joan Thorholm	Admissions Dir	349		349
Skillpath National	Leadership Seminar	Arlington Hts IL	Celia Banuelos	Housekeeping Dir	199		199
Gertrude Walsh	Food Handlers Certification	online	Gerrude Walsh	Asst. Social Services	10		10
HINSeminars	New Requirements of Participation	Schaumburg, IL	Elena Tamvakis	Asst. Social Services	199		199
Leading Age	2017 Annual Meetg & Expo	Chicago IL	Mark Davis	Social Services Dir	364		364
Mark Davis	Food Handlers Certification	online	Mark Davis	Social Services Dir	13		13
Harper Quyikpay	Job Fair	Prospect Hts, IL	Mordechai Finkel	HR Director	249		249
	Business Process Review Training	Wheeling IL	Mark Murphey	Administrator	2,072		2,072
HINSeminars	Medicare Forum	Schamuburg, IL	Mark Murphey	Administrator	199		199
NBI	Advanced Employment Law	Eau Claire, WI	Mordechai Finkel	HR Director	349		349
NBI	Advanced Employment Law	Eau Claire, WI	Mark Murphey	Administrator	349		349
Leading Age	Workforce Summit	Lisle IL	Mordechai Finkel	HR Director	234		234
Leading Age	Workforce Summit	Lisle IL	Mark Murphey	Administrator	234		234
Skillpath National	Managing Multiple Proj, Obj & Deadlines	Chicago IL	Pat Gerbanas	Bus Development	32	32	-
Skillpath National	Managing Multiple Proj, Obj & Deadlines	Chicago IL	Pat Gerbanas	Bus Development	149	149	-
Skillpath National	Managing Multiple Proj, Obj & Deadlines	Chicago IL	Mark Murphey	Administrator	149		149
	State Sanitation Course	Wheeling IL	Non Dietary Staff		716		716
NBI	2016 Medicare Update	Chicago IL	Wendy Campos	Case Mgmt Dir	359		359
	State Sanitation Course	Wheeling IL	Non Dietary Staff		300		300
Food Safety Training	Food Handlers Certification	Online	Stuart Ruffin	Food Services Dir	10		10
Beckydormer.com	Regulatory LTC Requirements for Food/Nut	Webinar	Nancy Weiner	Food Serv Coord	33		33
Skillpath National	Defeating Procrastination		Mark Murphey	Administrator	169		169
Paypal	Long Term Care Nutritional Seminar		Stuart Ruffin	Food Serv Dir	130		130
Paypal	Long Term Care Nutritional Seminar		Nancy Weiner	Food Serv Coord	130		130
Illinois CPA Society	Healthcare Compliance Seminar	Des Plaines, IL	Paula Francis	Legal Counsel	250		250
Illinois CPA Society	Healthcare Compliance Seminar	Des Plaines, IL	Mark Murphey	Administrator	250		250
Illinois CPA Society	Healthcare Compliance Seminar	Des Plaines, IL	Effie Galetsis	CFO	205		205
	Fraud Symposium Seminar	Des Plaines, IL	Effie Galetsis	CFO	330		330
	Not for Profit conference seminar	Des Plaines, IL	Effie Galetsis	CFO	330		330
Food Safety Training	Food Handlers Certification	Online	Luda Strus	A/R	10		10
Food Safety Training	Food Handlers Certification	Online	Effie Galetsis	CFO	10		10
HINSeminars	New Requirements of Participation	Schaumburg, IL	Mark Murphey	Administrator	199		199
HINSeminars	New Requirements of Participation	Schaumburg, IL	Nancy Wener	Memory Care Dir	199		199
Leading Age	Foodservice Educational Seminar	Chicago IL	Fili, Mirela	Cook	230		230
Finkel, Mordehcai	Food Handlers Certification	Online	Finkel, Mordechai	HR Dir	10		10
Event Brite	CMS Preparedness Rule	Oak Brook, IL	Pat Gerbanas	Bus. Development	82	82	-
Illinois CPA Society	2017 Controllers Conference	Chicago IL	Effie Galetsis	CFO	355		355
Leading Age	Food Handlers Certification	Wheeling IL	Various Staff		350		350
Leading Age	Food Handlers Certification	Wheeling IL	Various Staff		300		300
Leading Age	Food Handlers Certification	Wheeling IL	Various Staff		288		288
Leading Age	Food Handlers Certification	Wheeling IL	Various Staff		100		100
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Wendy Campos	Case Mgmt Director	349		349
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Nordechai Finkel	HR Director	349		349
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Paula Francis	Legal Counsel	349		349
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Effie Galetsis	CFO	349		349
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Mark Murphey	Administrator	349		349
Leading Age	2017 Illinois Annual Meeting & Expo	Chicago IL	Pat Gerbanas	Bus Development	349	349	-
PESI	2017 Illinois Elder Law	Chicago IL	Wendy Campos	Case Mgmt Director	200		200
Relias Learning	Various	Online	Various Staff		7,870		7,870
							-
Total					29,744	1,911	27,833

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 06/01/16 Ending: 05/31/17

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. $ **57,260** 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. $ **394,340**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,791**

(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? **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