		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 4/1/2002

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua Banach **Telephone Number:** 847-628-8784
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 6/1/19 to 5/31/20 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) Denise A. Leonard, CPA, Partner
(Firm Name & Address) Plante Moran, PLLC, 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	35,628	10,584	6,569	52,781	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,628	10,584	6,569	52,781	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.71%

D. How many bed reserve days during this year were paid by the Department?
None (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 4/1/2002

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 188 and days of care provided 6,122

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: 5/31/2020 Fiscal Year: 5/31/2020

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	644,473	60,369	4,596	709,438		709,438		709,438			1
2	Food Purchase		504,761		504,761		504,761	(300)	504,461			2
3	Housekeeping	466,332	54,060	376	520,768		520,768		520,768			3
4	Laundry	117,554	21,411	7,528	146,493		146,493		146,493			4
5	Heat and Other Utilities			287,908	287,908		287,908	(16,222)	271,686			5
6	Maintenance	226,850	196,565		423,415		423,415		423,415			6
7	Other (specify):* Waste Removal & Sec			88,483	88,483		88,483		88,483			7
8	TOTAL General Services	1,455,209	837,166	388,891	2,681,266		2,681,266	(16,522)	2,664,744			8
	B. Health Care and Programs											
9	Medical Director			19,350	19,350		19,350		19,350			9
10	Nursing and Medical Records	5,304,856	268,581	7,545	5,580,982		5,580,982		5,580,982			10
10a	Therapy		3,300	738,032	741,332		741,332		741,332			10a
11	Activities	373,031	24,367	1,037	398,435		398,435		398,435			11
12	Social Services	215,167	2,317	9,013	226,497		226,497		226,497			12
13	CNA Training											13
14	Program Transportation			23,975	23,975		23,975		23,975			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,893,054	298,565	798,952	6,990,571		6,990,571		6,990,571			16
	C. General Administration											
17	Administrative	149,757			149,757		149,757		149,757			17
18	Directors Fees											18
19	Professional Services			240,129	240,129		240,129	(8,150)	231,979			19
20	Dues, Fees, Subscriptions & Promotions			55,981	55,981		55,981	(801)	55,180			20
21	Clerical & General Office Expenses	769,871	94,446	245,992	1,110,309		1,110,309	(189,252)	921,057			21
22	Employee Benefits & Payroll Taxes			1,682,402	1,682,402		1,682,402		1,682,402			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,052	15,052		15,052		15,052			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			345,446	345,446		345,446	32,238	377,684			26
27	Other (specify):* Marketing & Other A	232,114		66,572	298,686		298,686	(251,671)	47,015			27
28	TOTAL General Administration	1,151,742	94,446	2,651,574	3,897,762		3,897,762	(417,636)	3,480,126			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,500,005	1,230,177	3,839,417	13,569,599		13,569,599	(434,158)	13,135,441			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 & Nursing
SEMINAR EXPENSE
6/1/2019-5/31/2020

DATE	G/L ACCT#	PAYEE ON GL	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	AMOUNT	ADJUSTMENT	RECLASS	ADJUSTED AMOUNT
9/12/19	**51500-70**	Cardmember Service	American Case Manager	American Case sepminars	Joan Thorholm	Admissions Director	Rosemont, IL	475.00			
				American Case sepminars	Frances Stamatoukos	Marketing Director	Rosemont, IL	475.00			
7/31/19	**41010-70**	Pointclickcare Tech.	onsite training PCC	PCC users	All the users		Online	1,007.38			
8/6/19		Cardmember Service	HINSeminars	MDS coding for PDPM	Lora Lelis	DON	Schaumburg, IL	209.00			
			HINSeminars	MDS coding for PDPM	Julie Calimag	MDS	Schaumburg, IL	209.00			
			HINSeminars	MDS coding for PDPM	Jona Tad-y	MDS	Schaumburg, IL	209.00			
			HINSeminars	MDS coding for PDPM	Miriam Villareal	MDS	Schaumburg, IL	209.00			
9/10/19		American Express	Hin Seminars	Liverpool MDS seminars	Miriam Villareal	MDS	Schaumburg, IL	209.00			
			Hin Seminars	Liverpool MDS seminars	Diona Tad-y	MDS	Schaumburg, IL	209.00			
2/12/20		ACT Wecareonline	Rehab, seminars	Wecare seminars	Anna Maria Papadopoulos	Rehab. Aid	On line	225.00			
		ACT Wecareonline	Rehab, seminars	Wecare seminars	Eva Pasilias	Rehab. Aid	On line	225.00			
	41100-07	Payroll PPE 6/22/19						2,899.00			
7/25/19		American Express	Hin Seminars	Webinar:MDS Sect PDPB Strategies for therapy &	Julie Calimag	ADON	Wheeling IL	129.00			
2/11/20		Mizpah CTR for Allied Health Edu.	Feeding certificates	Feeding Seminars	CAN's and Activities Aids		Wheeling IL	700			
6/3/19	**54090-70**	Cardmember Service	Impact Networking	Impact optimize seminar	Aphrodite Athanasiadis	Medical Records	Navy Pier	400.00			
6/13/19		US Foodservice	Food for Seminars	Training			Wheeling IL	159.26			
8/6/19		Cardmember Service	HinSeminars	MDS coding for PDPM	Dino Varnavas	Administrator	Schaumburg, IL	209.00			
9/10/19		Hinshawlaw.com	Hinshaw seminars	HR training	Mordechai Finkel	HR Director	Wheeling IL	110.00			
9/18/19		American Express	EB Pointclickcare	Seminars PCC	Dino Varnavas	Administrator	Wheeling IL	100.00			
			EB Pointclickcare	Seminars PCC	Effie Galetsis	CFO	Wheeling IL				
10/1/19		Mordechai Finkel	Job Fair & Ttraining Experience	Training	Mordechai Finkel	HR Director	Wheeling IL	49.72			
12/6/19		Leadingage Illinois	Seminar	Training	Dino Varnavas	Administrator	Wheeling IL	79.00			
1/7/20		US Foodservice	Food for Seminars	Traning Staff			Wheeling IL	71.24			
1/29/20		Cardmember Service	Hin Seminars	Seminars for Maintenance Direc	Russ Staufenbiel	Maintenance Director	Wheeling IL	529.00			
1/8/20		Cardmember Service	NIU Outreach Dekalb	Annual meeting & Expo 3/17/20	Effie Galetsis	CFO	Schaumburg, IL	299.00			
12/1/19					Dino Varnavas	Administrator	Schaumburg, IL	299.00			
					Mordechai Finkel	HR Director		299.00			
					Francisco Sanchez	Food Service Director		299.00			
					Annie Carlson	Memory Care Director		299.00			
					Diana Chun	MDS		299.00			
					Mayra Quintana	Recreatin Coord. 4th floor		299.00			
					Julie Calimag	Restorative nurse managm.		299.00			
					Nalley Morales	Restorative nurse		299.00			
					Russ Staufenbiel	Maintenance Director		299.00			
					Helen Tamvakis	Social Services		299.00			
					Franses Stamatoukos	Marketing Director		299.00			
					Joan Thorholm	Admision Director		299.00			
					Karen Zimmer	DON		299.00			
					Harilkia Mahairas	Staffing Coordinator		299.00			
					Dimitri Demogiorgas	ADON		299.00			
					Lia Palivos	Hospital Liaison		299.00			
					Pat Gerbanas	Business Development		299.00			
3/4/20		Cardmember Service	NIU Outreach 815-753-5927	Annual meeting & Expo 3/17/20	Russ Staufenbiel	Maintenance Director		299.00			
Total								**14,777.60**	**0.00**	**0.00**	**14,777.60**

DATE	G/L ACCT #	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	TOLLS	PARKING	GAS	TRAIN	CAB	AIRFARE HOTEL	TOTAL
6/3/19	**54090-71**	Maryvil Robinson	Accounts Payable Acct	reimb for travel			29.70				29.70
6/3/19		Dino Varnavas	Administrator	parking-Evanston hospital			4.00				4.00
6/28/19		Margarita Denekos	Committee Coordinator	mileage			107.88				107.88
10/9/19		Maryvil Robinson	Case Management Dir.	reimb for travel			43.85				43.85
10/30/19		Margarita Denekos	Accounts Payable Acct	reimb for travel			89.32				89.32
Total					**0.00**	**0.00**	**274.75**	**0.00**	**0.00**	**0.00**	**274.75**

Total **15,052.35**

Sch. V, Line 24, col. 8

Facility Name & ID Number Greek American Rehab Care Ct #0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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			120,000	120,000		120,000	352,953	472,953			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							375,699	375,699			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			720,928	720,928		720,928	(720,928)				34
35	Rent-Equipment & Vehicles			41,374	41,374		41,374		41,374			35
36	Other (specify):*							54,663	54,663			36
37	TOTAL Ownership			882,302	882,302		882,302	62,387	944,689			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			268,611	268,611		268,611		268,611			39
40	Barber and Beauty Shops			1,151	1,151		1,151	(1,151)				40
41	Coffee and Gift Shops	19,192	806		19,998		19,998	(806)	19,192			41
42	Provider Participation Fee			384,358	384,358		384,358		384,358			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	19,192	806	654,120	674,118		674,118	(1,957)	672,161			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,519,197	1,230,983	5,375,839	15,126,019		15,126,019	(373,728)	14,752,291			45

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(300)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,269)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,875)	21		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	(8,438)	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	(171,730)	21		24
25	Fund Raising, Advertising and Promotional	(251,671)	27		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	(32,354)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (471,637)		$	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)	97,909		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 97,909		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (373,728)		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

Greek American Rehab Care Ct

ID# 0044149

Report Period Beginning: 6/1/19

Ending: 5/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty	$ (1,151)	40	1
2	Cable	(16,222)	5	2
3	Bank Charges	(5,209)	21	3
4	Gifts	(806)	41	4
5	Lobbying Expense	(816)	20	5
6	Legal Services Expense Non-Allowable	(8,150)	19	6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(32,354)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	(300)	0	0	0	0	0	0	0	0	0	0	(300)	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	(16,222)	0	0	0	0	0	0	0	0	0	0	(16,222)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,522)	0	0	0	0	0	0	0	0	0	0	(16,522)	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	(8,150)	0	0	0	0	0	0	0	0	0	0	(8,150)	19
20	Fees, Subscriptions & Promotions	(816)	15	0	0	0	0	0	0	0	0	0	(801)	20
21	Clerical & General Office Expenses	(189,252)	0	0	0	0	0	0	0	0	0	0	(189,252)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	32,238	0	0	0	0	0	0	0	0	0	32,238	26
27	Other (specify):*	(251,671)	0	0	0	0	0	0	0	0	0	0	(251,671)	27
28	**TOTAL General Administration**	(449,889)	32,253	0	0	0	0	0	0	0	0	0	(417,636)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(466,411)	32,253	0	0	0	0	0	0	0	0	0	(434,158)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab Care Ct **#** 0044149 **Report Period Beginning:** 6/1/19 **Ending:** 5/31/20

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	352,953	0	0	0	0	0	0	0	0	0	352,953	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,269)	378,968	0	0	0	0	0	0	0	0	0	375,699	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(720,928)	0	0	0	0	0	0	0	0	0	(720,928)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	54,663	0	0	0	0	0	0	0	0	0	54,663	36
37	**TOTAL Ownership**	(3,269)	65,656	0	0	0	0	0	0	0	0	0	62,387	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	(1,151)	0	0	0	0	0	0	0	0	0	0	(1,151)	40
41	Coffee and Gift Shops	(806)	0	0	0	0	0	0	0	0	0	0	(806)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,957)	0	0	0	0	0	0	0	0	0	0	(1,957)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(471,637)	97,909	0	0	0	0	0	0	0	0	0	(373,728)	45

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	$ 720,928	Hellenic American Care Foundation	100.00%	$	$ (720,928)	1
2	V	20	Dues and Subscriptions		Hellenic American Care Foundation	100.00%	15	15	2
3	V	26	Insurance		Hellenic American Care Foundation	100.00%	32,238	32,238	3
4	V	30	Depreciation		Hellenic American Care Foundation	100.00%	352,953	352,953	4
5	V	32	Interest		Hellenic American Care Foundation	100.00%	378,968	378,968	5
6	V	36	Mortgage Insurance		Hellenic American Care Foundation	100.00%	54,663	54,663	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 720,928			$ 818,837	$ * 97,909	14

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	Wheeling, Illnois	Building Co.	1
2					Care Foundation			2
3	Eleni Bousis							3
4	Peter G. Karahalios, JD							4
5	Lisa Palivos, MD				Wheeling Professional	Wheeling, Illnois	Medical Bldg	5
6	Alex Afshari				Building, LLC			6
7	Peter Kopsaftis							7
8	Paula A Tolan-Francis, JD							8
9	Nicholas Pishos				Paterakis Center, LTD	Wheeling, Illnois	Senior Center	9
10	Robert S Fakouri, JD							10
11	Angelo G Gianopulos							11
12	Nicholas A Lalios, DPM				Compassionate Love	Wheeling, Illnois	Day Care	12
13	George Reveliotis, JD				Day Care			13
14	Theresa Tzakis							14
15	James G Romas							15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	See Listing of Board Members On Page 6-Supplemental										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	$44,979.93	9/1/2013	$ 10,924,500	$ 10,010,869	4/1/2052	3.7700	$ 380,677	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,979.93		$ 10,924,500	$ 10,010,869			$ 380,677	9
	B. Non-Facility Related*											
10	Interest Income - Building		X								(1,709)	10
11	Interest Income		X								(3,269)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,978)	14
15	TOTALS (line 9+line14)						$ 10,924,500	$ 10,010,869			$ 375,699	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 54,663 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.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

N/A-Exempt

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Joshua Banach

TELEPHONE 847-628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 6/1/19 Ending: 5/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 425,000	1
2					2
3	TOTALS			$ 425,000	3

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	Tiles for Front Hall			2018	4,462						27
28	Flagpole			2018	2,405						28
29	New exhaust roof			2018	5,513						29
30	Chapel Flooring			2018	3,156						30
31	Dining Room Remodel			2018	1,685						31
32	Exterior Canopy			2018	3,240						32
33	Elevator Area Remodel			2018	1,650						33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	Remodel rooms 320-324; description below	2018	$ 36,740	$		$	$	$	37
38	Millwork, flooring tile, bathroom tile								38
39	Remodel rooms 320-324; description below	2018	74,540						39
40	Flooring tile, wall finishing, fireplace area tiling								40
41	4th floor painting	2018	1,500						41
42	Upgrade elevator key pads on all four floors	2018	5,724						42
43	Remodel rooms 320-324; description below	2018	50,000						43
44	Wall and floor tile for resident rooms, window millwork								44
45	Compressor	2018	4,564						45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,046,869	$		$	$	$	70

**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: 6/1/19 Ending: 5/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 13,046,869	$		$	$	$	1
2									2
3	Hellenic American Care Foundation								3
4									4
5									5
6	Various	2008	135,666						6
7	Various	2011	20,415						7
8	Various	2012	39,343						8
9	Various	2013	48,569						9
10	Parking Lot - Paving	2016	66,261						10
11	Boiler Room - Hot Water Tank	2017	70,060						11
12	Flooring for Chapel	2018	2,450						12
13	Remodel room 319 - description below	2018	12,600						13
14	Framing, drywall, ceiling, plumbing, eletrical								14
15	Remodel room 319 - description below	2018	18,070						15
16	Eletrical, sprinkler system, paint, floor, tile, millwork								16
17	Renovation of room 319	2018	68,178						17
18	Room 313, 314, 320, 321, 322, 323, and 324 remodeling	2019	400,208						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	Depreciation - Greek American Rehab and Care Center, Inc.			120,000		120,000		2,219,690	32
33	Depreciation - Hellenic American Care Foundation			352,953		352,953		7,674,365	33
34	TOTAL (lines 1 thru 33)		$ 13,928,689	$ 472,953		$ 472,953	$	$ 9,894,055	34

**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: 6/1/19 Ending: 5/31/20

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	$ 1,163,010	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,163,010	$	$	$		$	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 E4550	2007	$ 63,300	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 63,300	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,579,999	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 472,953	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 472,953	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)	$ 9,894,055	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	N/A						4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 41,374 Description: See Supplemental
(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.

Greek American Rehab & Nursing
MOVABLE EQUIPMENT RENTAL
SUPPLEMENTAL SCHEDULE
06/01/2019-5/31/2020

Account Number	Make	Model Year	Monthly Lease Payment	Rental Expense for this Period
50000-50		water cooler	175.00	1,750.00
		ice maker	225.00	2,475.00
41250-50				
		oxygen tanks		10,147.00
		Restmed V-pap		1,581.00
		SCD express		1,372.50
		Broda		2,841.00
		Foam mettress		1,896.50
		Floor bed		576.00
		Floor bed safty		96.00
		Foot pump Garment		2,242.00
		Bariatric bed		3,720.00
		Pressure mattress system		3,690.00
		Wheelchairs		36.00
		O2 concentrator		177.00
		Alternat. Press. mattress sys.		1,031.50
		AP mattress syst.		1,380.00
		Bed safty		446.00
54090-50		Copystar CS 5002i printer	203.76	2,263.01
		Kyocera acc. Printer Warehouse	184.00	984.22
		Kyocera 6530 cdn printer	117.42	447.26
		Copystar CS 6002i printer	370.37	2,222.22
	TOTAL			41,374.21

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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.

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	V10A	0.00	hrs	$ 0	4,832	$ 295,723	$ 0	4,832	$ 295,723	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	1,763	107,871	0	1,763	107,871	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	3,300		3,300	3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	5,465	334,438	0	5,465	334,438	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	0.00	hrs	0	0	0	0			8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	217,994		217,994	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	50,617		50,617	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	0			13
14	TOTAL				$	12,060	$ 738,032	$ 271,911	12,060	$ 1,009,943	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.

STATE OF ILLINOIS

Facility Name & ID Number Greek American Rehab Care Ct **#** 0044149 **Report Period Beginning:** 6/1/19 **Ending:** 5/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 5/31/20 **(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	$ 2,630,637	$ 2,752,395	1
2	Cash-Patient Deposits	220,964	220,964	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,659,724	1,659,724	3
4	Supply Inventory (priced at)	78,288	78,288	4
5	Short-Term Investments			5
6	Prepaid Insurance	132,749	132,749	6
7	Other Prepaid Expenses	415,667	415,667	7
8	Accounts Receivable (owners or related parties)		51,471	8
9	Other(specify): See Attached	(4,133)	(4,133)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,133,896	$ 5,307,125	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	1,112,493	12,751,573	14
15	Leasehold Improvements, at Historical Cost		1,428,359	15
16	Equipment, at Historical Cost	1,552,935	3,159,730	16
17	Accumulated Depreciation (book methods)	(2,106,152)	(9,780,516)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		(12,220)	21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	103,478	631,211	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 662,754	$ 8,603,137	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,796,650	$ 13,910,262	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 335,540	$ 335,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	196,595	196,595	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	655,288	655,288	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		31,951	33
34	Deferred Compensation	3,923	3,923	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	220,591	220,591	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,411,937	$ 1,443,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,010,869	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached			43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,010,869	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,411,937	$ 11,454,757	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,384,712	$ 2,455,505	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,796,649	$ 13,910,262	48

***(See instructions.)**

Greek American Rehab Care Ct
0044149
5/31/20
Page 17 Support

PG 17 Line 9 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1070.10	10051-00	Operating transfers from/to tr	362.00
1070.10	11900-00	Refunds Due/Clearing Acct.	(4,495.00)
Total			**(4,133.00)**

PG 17 Line 23 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1080.1	11905-00	Medicare receivable	69,482.00
1410.3	13400-00	Capital deposit Trinity Risk	33,696.00
1410.3	13500-00	deposits	300.00
Hellenic American Care Foundation			
	11100	Insurance escrow	29,035.00
	11120	Replacement reserve escrow	377,297.00
	11300	MIP escrow	33,793.00
	13000	Prepaid MIP	16,717.00
	18000	Loan fees	70,891.00
Total			**631,211.00**

PG 17 Line 37 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
2090.3	21600-00	bcbs- upp	(3,547.00)
2090.3	23000-00	due to resident trust	176,258.00
2090.40	21010-00	accrued expenses - bed tax	47,880.00
Total			**220,591.00**

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,938,297	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,938,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	283,966	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)**	$ 283,966	17
	B. Transfers (Itemize):		
18			18
19	Net asset transfer	(2,837,551)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,837,551)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,384,712	24 *

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	$ 16,084,965	1
2	Discounts and Allowances for all Levels	(3,860,656)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,224,309	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,091,664	6
7	Oxygen	(910)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,090,754	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,200	13
14	Non-Patient Meals	300	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	220,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,443	19
20	Radiology and X-Ray		20
21	Other Medical Services	29,815	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 284,485	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,269	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,269	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Rebate Income/HHS Provider Relief Funds	807,168	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 807,168	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,409,985	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,681,266	31
32	Health Care	6,990,571	32
33	General Administration	3,897,762	33
	B. Capital Expense		
34	Ownership	882,302	34
	C. Ancillary Expense		
35	Special Cost Centers	289,760	35
36	Provider Participation Fee	384,358	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,126,019	40
41	**Income before Income Taxes (line 30 minus line 40)****	283,966	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 283,966	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,279,071	44
45	Private Pay - Net Inpatient Revenue	2,949,244	45
46	Medicare - Net Inpatient Revenue	3,798,650	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	245,194	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(2,047,850)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,224,309	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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	2,072	2,288	$ 125,550	$ 54.87	1
2	Assistant Director of Nursing	387	560	23,468	41.91	2
3	Registered Nurses	54,413	57,428	1,732,799	30.17	3
4	Licensed Practical Nurses	35,888	38,142	983,239	25.78	4
5	CNAs & Orderlies	180,098	186,742	2,340,869	12.54	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,549	1,991	47,294	23.75	9
10	Activity Assistants	21,000	22,412	325,737	14.53	10
11	Social Service Workers	6,616	7,547	215,167	28.51	11
12	Dietician	2,024	2,120	64,450	30.40	12
13	Food Service Supervisor	2,024	2,120	67,465	31.82	13
14	Head Cook	9,555	10,096	183,850	18.21	14
15	Cook Helpers/Assistants	23,032	24,694	328,708	13.31	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	8,918	9,596	226,850	23.64	17
18	Housekeepers	32,735	34,765	466,332	13.41	18
19	Laundry	7,696	8,448	117,554	13.92	19
20	Administrator	2,000	2,164	149,757	69.20	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	19,431	21,347	688,275	32.24	22
23	Office Manager	0	0	0		23
24	Clerical	4,300	4,553	81,595	17.92	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,944	4,266	98,930	23.19	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	9,902	10,666	251,306	23.56	33
34	TOTAL (lines 1 - 33)	427,584	451,945	$ 8,519,195 *	$ 18.85	34

* 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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	1,037	11-3	44
45	Social Service Consultant	85	7,941	12-3	45
46	Other(specify) Administrative		13,333	21-3	46
47	Memory Care	55	1,072	12-3	47
48	Human Resources Consultant		1,296	21-3	48
49	TOTAL (lines 35 - 48)	195	$ 24,679		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	38	$ 1,512	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	38	$ 1,512		53

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dino Varnavas	Administrator	0	$ 149,757
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,757

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
Hinshaw & Culberston, LLP	Legal Fees	$ 8,150
Plante Moran, PLLC	Accounting / Audit	73,433
Consulting	Payroll Processing	37,056
Consulting	Server Consulting	108,203
Consulting	Data Processing	13,287
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 240,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,890
Unemployment Compensation Insurance	
FICA Taxes	577,241
Employee Health Insurance	868,358
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	21,601
Vision Insurance	3,291
Disability Insurance	15,095
Life Insurance	17,561
403(B) Plan	8,977
Other Employee Benefits	51,389
Employee Background Checks	999
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,682,402

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	1,770
Dues and Subscriptions	49,415
Alloc. - Hellenic Related Party	15
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,180

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	275
Seminar Expense	14,778
See PG 3 Supp for detail	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,052

* Attach copy of IMRF notifications

**See instructions.

Greek American Rehab & Nursing

06/01/2019 - 05/31/2020

FY2020 Legal Fees

Effective Date	Payee/Vendor	Type of Serivce Provided	Amount	Adjustment	Adjusted Amount
10/22/19	Hinshaw & Culbertson	Corporate Reorganization	285.00	285.00	0.00
12/09/19	Hinshaw & Culbertson	General & Reorganization	5,315.00	5,315.00	0.00
12/19/19	Hinshaw & Culbertson	Corporate Reorganization	1,305.00	1,305.00	0.00
03/12/20	Hinshaw & Culbertson	General - Alcohol/Drug policy	225.00	225.00	0.00
05/07/20	Hinshaw & Culbertson	COVID Media Statement & procedures	1,020.00	1,020.00	0.00
		TOTAL	**8,150.00**	**8,150.00**	**0.00**

Facility Name & ID Number Greek American Rehab Care Ct # 0044149 Report Period Beginning: 6/1/19 Ending: 5/31/20

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: $13,606**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,919** 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. $ **384,358**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **300** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **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 out of Schedule V? **Yes**

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