

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149 Report Period Beginning: 06/01/08 Ending: 05/31/09

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>204</u>	Skilled (SNF)	<u>204</u>	<u>74,460</u>	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	<u>204</u>	TOTALS	<u>204</u>	<u>74,460</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>18,162</u>		<u>8,182</u>	<u>26,344</u>	8
9	SNF/PED					9
10	ICF	<u>22,119</u>	<u>13,167</u>	<u>305</u>	<u>35,591</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>40,281</u>	<u>13,167</u>	<u>8,487</u>	<u>61,935</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.18%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 04/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/2002 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 204 and days of care provided 8,182

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 05/31/2009 Fiscal Year: 05/31/2009

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

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/08 Ending: 05/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	478,381	37,718	22,336	538,435		538,435		538,435		1
2	Food Purchase		361,713		361,713		361,713	(3,537)	358,176		2
3	Housekeeping	415,018	68,618		483,636		483,636		483,636		3
4	Laundry	137,402	16,738	4,504	158,644		158,644		158,644		4
5	Heat and Other Utilities			366,399	366,399		366,399	(429)	365,970		5
6	Maintenance	91,372	16	268,575	359,963		359,963	(27,076)	332,887		6
7	Other (specify):*										7
8	TOTAL General Services	1,122,173	484,803	661,814	2,268,790		2,268,790	(31,042)	2,237,748		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	4,210,025	275,719	8,592	4,494,336		4,494,336		4,494,336		10
10a	Therapy	171,426	14,135		185,561		185,561		185,561		10a
11	Activities	210,602	8,278	2,925	221,805		221,805		221,805		11
12	Social Services	107,651	619	7,145	115,415		115,415		115,415		12
13	CNA Training										13
14	Program Transportation			75	75		75		75		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,699,704	298,751	29,537	5,027,992		5,027,992		5,027,992		16
	C. General Administration										
17	Administrative	71,503			71,503		71,503		71,503		17
18	Directors Fees										18
19	Professional Services			179,084	179,084		179,084	(69,449)	109,635		19
20	Dues, Fees, Subscriptions & Promotions			56,867	56,867		56,867	(2,595)	54,272		20
21	Clerical & General Office Expenses	474,969	59,047	485,000	1,019,016		1,019,016	(356,450)	662,566		21
22	Employee Benefits & Payroll Taxes			1,069,544	1,069,544		1,069,544		1,069,544		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,839	7,839		7,839		7,839		24
25	Other Admin. Staff Transportation			2,972	2,972		2,972	(1,722)	1,250		25
26	Insurance-Prop.Liab.Malpractice			169,798	169,798		169,798	17,212	187,010		26
27	Other (specify):*										27
28	TOTAL General Administration	546,472	59,047	1,971,104	2,576,623		2,576,623	(413,004)	2,163,619		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,368,349	842,601	2,662,455	9,873,405		9,873,405	(444,046)	9,429,359		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Greek American Rehab & Care Ctr

#0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			136,318	136,318		136,318	(32,579)	103,739			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,672	37,672		37,672	866,233	903,905			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,170,055	1,170,055		1,170,055	(1,168,172)	1,883			34
35	Rent-Equipment & Vehicles			10,583	10,583		10,583		10,583			35
36	Other (specify):*							54,220	54,220			36
37	TOTAL Ownership			1,354,628	1,354,628		1,354,628	(280,298)	1,074,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	90,592	339,224	723,830	1,153,646		1,153,646		1,153,646			39
40	Barber and Beauty Shops			2,096	2,096		2,096	(2,096)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,212	112,212		112,212	(522)	111,690			42
43	Other (specify):*	62,676		224,165	286,841		286,841	(286,841)				43
44	TOTAL Special Cost Centers	153,268	339,224	1,062,303	1,554,795		1,554,795	(289,459)	1,265,336			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,521,617	1,181,825	5,079,386	12,782,828		12,782,828	(1,013,803)	11,769,025			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Greek American Rehab & Care Ctr

ID# 0044149

Report Period Beginning: 06/01/08

Ending: 05/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (62,676)	43	1
2	Marketing Events	(2,226)	43	2
3	Other Marketing Expense	(1,476)	43	3
4	Bank Charges	(4,697)	21	4
5	Referral Fees	(6,975)	21	5
6	Flowers & Gifts	(2,005)	20	6
7	Barber & Beauty Expense	(2,096)	40	7
8	Collection Fees	(116)	21	8
9	Dining Room Rental	(335)	02	9
10	Miscellaneous Income	(827)	21	10
11	Meals	(1,722)	25	11
12	Various Foundation/Fundraising Expenses	(220,463)	43	12
13	Late Fees- Building Company	(1,566)	21	13
14	Amortization- Building Company	(562)	36	14
15	Accounting & Audit Fees- Building Company	(8,000)	19	15
16	Licenses & Fees- Building Company	(250)	20	16
17	Bank Charges- Building Company	(42)	21	17
18	Excess Provider Fee	(522)	42	18
19	Non-Allowable Legal Fees	(69,449)	19	19
20	Capitalized R&M	(27,076)	06	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	(413,081)		49

Greek American Rehab & Care Ctr

ID# 0044149

Report Period Beginning: 06/01/08

Ending: 05/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab & Care Ctr# 0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,537)											(3,537)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(429)											(429)	5
6	Maintenance	(27,076)											(27,076)	6
7	Other (specify):*													7
8	TOTAL General Services	(31,042)											(31,042)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(77,449)	8,000										(69,449)	19
20	Fees, Subscriptions & Promotions	(2,845)	250										(2,595)	20
21	Clerical & General Office Expenses	(358,058)	1,608										(356,450)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(1,722)											(1,722)	25
26	Insurance-Prop.Liab.Malpractice		17,212										17,212	26
27	Other (specify):*													27
28	TOTAL General Administration	(440,074)	27,070										(413,004)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(471,116)	27,070										(444,046)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab & Care Ctr# 0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(572,085)	539,506										(32,579)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,557)	868,790										866,233	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,168,172)										(1,168,172)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(562)	54,782										54,220	36
37	TOTAL Ownership	(575,204)	294,906										(280,298)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(2,096)											(2,096)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(522)											(522)	42
43	Other (specify):*	(286,841)											(286,841)	43
44	TOTAL Special Cost Centers	(289,459)											(289,459)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,335,779)	321,976										(1,013,803)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,168,172	Greek American Nursing & Real Estate	100.00%	\$	(1,168,172)	1
2	V	32 Interest	925	Greek American Nursing & Real Estate	100.00%	869,715	868,790	2
3	V	36 MIP Insurance		Greek American Nursing & Real Estate	100.00%	54,220	54,220	3
4	V	36 Amortization		Greek American Nursing & Real Estate	100.00%	562	562	4
5	V	19 Accounting & Audit Fees		Greek American Nursing & Real Estate	100.00%	8,000	8,000	5
6	V	30 Depreciation		Greek American Nursing & Real Estate	100.00%	539,506	539,506	6
7	V	26 General Insurance		Greek American Nursing & Real Estate	100.00%	17,212	17,212	7
8	V	20 Licenses & Fees		Greek American Nursing & Real Estate	100.00%	250	250	8
9	V	21 Bank Charges & Late Fees		Greek American Nursing & Real Estate	100.00%	1,608	1,608	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,169,097			\$ 1,491,073	\$ * 321,976	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

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Report Period Beginning:

06/01/08

Ending: 05/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending: 05/31/09

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr # 0044149 Report Period Beginning: 06/01/08 Ending: 05/31/09

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Cambridge Realty Capital		X	Mortgage	\$77,989.00	10/1/2001	\$ 11,275,000	\$ 10,853,225	04/01/2040	7.9000	\$ 860,304	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	First Bank		X	Line of Credit							37,672	6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$77,989.00		\$ 11,275,000	\$ 10,853,225			\$ 897,976	9								
B. Non-Facility Related*																				
10	Interest Income		X								(2,557)	10								
11	Int. Income- Building C.		X								(925)	11								
12	Interest Exp- Residual Receipts		X								9,411	12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ 5,929	14								
15	TOTALS (line 9+line14)						\$ 11,275,000	\$ 10,853,225			\$ 903,905	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 54,220 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

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

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1994</u>	<u>\$ 425,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 425,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2001		58,125		20	2,906	2,906	16,811	9
10	Various		2003		16,264		20	813	813	5,421	10
11	Various		2005		3,121		20	156	156	624	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		11,639,080	290,977			(290,977)		67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			136,318			(136,318)		69
70	TOTAL (lines 4 thru 69)		\$ 11,716,590	\$ 427,295		\$ 3,876	\$ (423,420)	\$ 22,856	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,716,590	\$ 427,295		\$ 3,876	\$ (423,420)	\$ 22,856	1
2	Generator Repair	2006	13,576		20	679	679	2,715	2
3	Door	2006	9,864		20	493	493	1,973	3
4	Painting	2006	10,000		20	500	500	2,000	4
5	Trash Compactor	2006	3,577		20	179	179	715	5
6	Elevator Repairs	2006	3,197		20	160	160	480	6
7	Piping	2006	4,580		20	229	229	687	7
8	Elevator Repairs	2006	3,197		20	160	160	480	8
9	Elevator Repairs	2006	3,402		20	170	170	510	9
10	Olympic Carpets - \$20,000 Donation Included In Cost	2007	40,000		20	889	889	2,667	10
11	Olympic Carpets - \$6,186.88 Donation Included In Cost	2007	11,687		20	260	260	780	11
12	Olympic Carpets - \$6,158.08 Donation Included In Cost	2007	11,658		20	259	259	777	12
13	Olympic Carpets - \$10,955.44 Donation Included In Cost	2007	20,955		20	466	466	1,398	13
14	Olympic Carpets - \$13,000 Donation Included In Cost	2007	26,000		20	578	578	1,734	14
15	Walls, Flooring, Carpeting, Painting	2007	13,440		20	224	224	672	15
16	Olympic Carpets - \$115,806 Donation Included In Cost	2007	195,806		20	6,993	6,993	20,979	16
17	Olympic Carpets - \$10,955.44 Donation Included In Cost	2007	20,955		20	349	349	1,047	17
18	Medline	2007	907		20	11	11	33	18
19	Walls, Flooring, Carpeting, Painting	2007	4,200		20	53	53	159	19
20	Walls, Flooring, Carpeting, Painting	2007	6,000		20	25	25	75	20
21	Fire Safety System	2007	4,380		20	219	219	657	21
22	Piping	2007	3,458		20	173	173	519	22
23	Piping	2007	3,110		20	156	156	468	23
24	Carpet - \$7,462 Donation	2007	14,622		20	1,915	1,915	3,830	24
25	Remodeling - Painting	2007	20,305		20	846	846	1,692	25
26	Wall Protection	2007	12,145		20	506	506	1,012	26
27	Wall Protection	2007	9,876		20	412	412	824	27
28	Wall Protection	2007	2,364		20	89	89	178	28
29	Cove Base - \$1,872 Donation	2007	4,368		20	468	468	936	29
30	Carpet Labor Charge	2007	300		20	32	32	64	30
31	Carpeting - \$580 Donation	2007	1,680		20	160	160	320	31
32	Wall Protection	2007	1,624		20	54	54	108	32
33	Ip Wall Protection	2007	21,055		20	702	702	1,404	33
34	TOTAL (lines 1 thru 33)		\$ 12,218,878	\$ 427,295		\$ 22,284	\$ (405,011)	\$ 74,749	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,218,878	\$ 427,295		\$ 22,284	\$ (405,011)	\$ 74,749	1
2	Cove Base, Carpet - \$74,446 Donation	2007	139,446		20	13,281	13,281	26,562	2
3	Ipcc Wall Protection	2007	1,692		20	49	49	98	3
4	Locks	2007	1,000		20	117	117	234	4
5	Wood Rods, Holders, Rings	2008	884		20	74	74	148	5
6	Remodeling - Painting	2008	11,590		20	193	193	386	6
7	Carpet, Cove Base - \$75,584 Donation	2008	144,584		20	6,885	6,885	13,770	7
8	Ipcc Wall Protection	2008	4,639		20	58	58	116	8
9	Exhaust Vent	2008	1,500		20	25	25	50	9
10	Cove Base, Carpet - \$53,446 Donation	2008	78,446		20	934	934	1,868	10
11	Repair Heater	2008	2,599		20	130	130	130	11
12	Rebuild Fireboxes For 2 Rite Boilers	2008	12,000		20	600	600	600	12
13	Fix Boiler #1	2008	4,200		20	210	210	210	13
14	Elevator Repairs	2008	3,592		20	180	180	180	14
15	Olympic Carpet- Halls And Rooms	2008	2,860		20	286	286	286	15
16	Beauty Shop	2008	1,880		20	94	94	94	16
17	In Pro Corp- Wall Protectors	2008	11,286		20	846	846	846	17
18	In Pro Corp- Wall Protectors	2008	1,749		20	87	87	87	18
19	Fine Dining Room	2008	600		20	60	60	60	19
20	Cover Plate	2008	516		20	52	52	52	20
21	Countertop For Coffee Area	2008	829		20	48	48	48	21
22	Curtains For Fine Dining Room	2008	2,000		20	100	100	100	22
23	Garcc- Clear Plexiglass	2008	827		20	41	41	41	23
24	Curtains For Fine Dining Room	2008	1,500		20	75	75	75	24
25	Shades- Fine Dining Room	2008	722		20	36	36	36	25
26	Medline Industries- Monitor- Security System	2008	6,579		20	329	329		26
27	Repairs To Piping System	2009	4,685		20	234	234	234	27
28	Stanely Access Tech- Patio Back Door	2009	2,330		20	78	78	78	28
29	Kleinco Llc- Building Improvements	2009	15,072		20	126	126	126	29
30	Kleinco Llc- Repair And Building Improvements	2009	1,433		20	12	12	12	30
31	Outpatient Therapy Room	2009	5,000		20	125	125	125	31
32	Ar & Jk Construction - Outpatient Therapy Room	2009	4,000		20	67	67	67	32
33	Ar & Jk Construction - Outpatient Therapy Room	2009	5,000		20	42	42	42	33
34	TOTAL (lines 1 thru 33)		\$ 12,693,918	\$ 427,295		\$ 47,759	\$ (379,536)	\$ 121,511	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,693,918	\$ 427,295		\$ 47,759	\$ (379,536)	\$ 121,511	1
2	Village Of Wheeling- Outpatient Therapy Room	2009	80		20	1	1	1	2
3	Mirror	2009	550		20	5	5	5	3
4	Intercom	2009	1,200		20	14	14	14	4
5	Ar & Jk Construction - Outpatient Therapy	2009	4,550		20	38	38	38	5
6	Olympic Carpet- Vinyl Base	2009	194		20	2	2	2	6
7	Aluminum Sign	2009	237		20	2	2	2	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,700,729	\$ 427,295		\$ 47,821	\$ (379,474)	\$ 121,573	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,700,729	\$ 427,295		\$ 47,821	\$ (379,474)	\$ 121,573	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,700,729	\$ 427,295		\$ 47,821	\$ (379,474)	\$ 121,573	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Building- 204 Beds	2001	11,639,080	290,977	40	290,977		2,036,839	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Greek American Rehab & Care Ctr**

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 11,639,080	\$ 290,977		\$ 290,977	\$	\$ 2,036,839

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$ 290,977	\$ 290,977	\$ 2,036,839	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$	\$		\$ 290,977	\$ 290,977	\$ 2,036,839	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning:

06/01/08

Ending:

05/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,722,675	\$ 248,529	\$ 48,569	\$ (199,960)	10	\$ 125,107	71
72	Current Year Purchases	6,272		627	627	10	627	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,728,947	\$ 248,529	\$ 49,196	\$ (199,333)		\$ 125,734	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	IBS Ford E450	2007	\$ 63,300	\$	\$ 3,768	\$ 3,768	5	\$ 11,304	76
77	Facility	Jeep Compass	2008	19,700		2,955	2,955	5	5,910	77
78										78
79										79
80	TOTALS			\$ 83,000	\$	\$ 6,723	\$ 6,723		\$ 17,214	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)	\$ 14,937,676	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 675,824	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,739	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (572,085)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,338,199	85

**

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6	Storage				<u>1,883</u>			6
7	TOTAL				\$ <u>1,883</u>			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: _____*

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: \$ 10,583 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 226,654	\$		\$ 226,654	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	90,592		505			91,097	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			474,060			474,060	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				311,223		311,223	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					22,611	28,001		50,612	13
14	TOTAL			\$ 90,592		\$ 723,830	\$ 339,224		\$ 1,153,646	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning: 06/01/08

Ending:

05/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 958,231	\$ 958,231	1
2	Cash-Patient Deposits	48,897	48,897	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,753,253	1,753,253	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	473,432	473,432	5
6	Prepaid Insurance	210,416	241,546	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	150,585	150,585	8
9	Other(specify): <u>See Attached Schedule</u>	11,806	475,978	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,606,620	\$ 4,101,922	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	727,155	1,156,263	15
16	Equipment, at Historical Cost	596,961	1,817,307	16
17	Accumulated Depreciation (book methods)	(412,932)	(3,751,468)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		17,619	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 911,184	\$ 11,303,801	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,517,804	\$ 15,405,723	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,013,021	\$ 1,013,021	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	160,856	160,856	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	356,468	356,468	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		71,450	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	109,090	109,090	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,639,435	\$ 1,710,885	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,853,225	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	150,584	354,408	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 150,584	\$ 11,207,633	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,790,019	\$ 12,918,518	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,727,785	\$ 2,487,205	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,517,804	\$ 15,405,723	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,035,826	1
2	Restatements (describe):		2
3	Rounding Adjustment	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,035,824	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	691,961	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)	\$ 691,961	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,727,785	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr# 0044149Report Period Beginning: 06/01/08Ending: 05/31/09

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,533,151	1
2	Discounts and Allowances for all Levels	(2,947,537)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,585,614	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,323,485	6
7	Oxygen	1,008	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,324,493	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	100,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,202	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	335	16
17	Sale of Drugs	302,456	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,262	19
20	Radiology and X-Ray		20
21	Other Medical Services	38,345	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 462,600	23
D. Non-Operating Revenue			
24	Contributions	(168)	24
25	Interest and Other Investment Income***	2,557	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,389	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,099,693	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,099,693	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,474,789	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,268,790	31
32	Health Care	5,027,992	32
33	General Administration	2,576,623	33
B. Capital Expense			
34	Ownership	1,354,628	34
C. Ancillary Expense			
35	Special Cost Centers	1,442,583	35
36	Provider Participation Fee	112,212	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,782,828	40
41	Income before Income Taxes (line 30 minus line 40)**	691,961	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 691,961	43

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

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

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

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

Facility Name & ID Number Greek American Rehab & Care Ctr

0044149

Report Period Beginning: 06/01/08

Ending: 05/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,907	2,370	\$ 96,862	\$ 40.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	46,256	51,967	1,553,849	29.90	3
4	Licensed Practical Nurses	23,373	25,159	712,123	28.30	4
5	CNAs & Orderlies	129,453	137,765	1,816,290	13.18	5
6	CNA Trainees					6
7	Licensed Therapist	2,129	2,268	90,592	39.94	7
8	Rehab/Therapy Aides	11,701	12,448	171,426	13.77	8
9	Activity Director	1,443	1,547	45,562	29.45	9
10	Activity Assistants	15,598	16,300	165,040	10.12	10
11	Social Service Workers	3,444	3,718	107,651	28.95	11
12	Dietician					12
13	Food Service Supervisor	6,676	7,177	105,562	14.71	13
14	Head Cook	9,855	10,597	155,860	14.71	14
15	Cook Helpers/Assistants	23,386	24,550	216,959	8.84	15
16	Dishwashers					16
17	Maintenance Workers	3,423	3,637	91,372	25.12	17
18	Housekeepers	40,933	42,729	415,018	9.71	18
19	Laundry	15,610	16,328	137,402	8.42	19
20	Administrator	790	870	71,503	82.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,922	22,549	474,969	21.06	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	1,237	1,341	30,901	23.05	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,576	3,844	62,676	16.30	33
34	TOTAL (lines 1 - 33)	361,712	387,164	\$ 6,521,617 *	\$ 16.84	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	480	\$ 22,336	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant	Monthly	3,870	10-03	37
38	Nurse Consultant	Monthly	4,722	10-03	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	51	2,925	11-03	44
45	Social Service Consultant	92	7,145	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	623	\$ 51,798		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Helen Infantis	Administrator	0.00%	\$ 71,503	Workers' Compensation Insurance	\$ 137,583	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,907	Advertising: Employee Recruitment	33,250	
				FICA Taxes	457,194	Health Care Worker Background Check		
				Employee Health Insurance	431,052	(Indicate # of checks performed <u>156</u>)	1,555	
				Employee Meals		Patient Background Checks <u>160</u>	1,600	
				Illinois Municipal Retirement Fund (IMRF)*		Dues, Subscriptions, Memberships	17,867	
				Other Employee Benefits	16,839	Advertising	590	
				401 (K) Contributions	17,969			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,503	TOTAL (agree to Schedule V, line 22, col.8)		\$ 54,272		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (590)	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 54,272	
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal	\$ 79,940			\$	Out-of-State Travel	\$	
Frost, Ruttenberg & Rothblatt	Accounting	62,693						
2401 Incorporated	Architectural Service	2,205				In-State Travel		
Galetsis & Associates	Accounting	17,086						
Pinnacle Consulting	Cust. Satisfaction Consult	3,600				Seminar Expense	7,839	
Achieve Accreditation	Accreditation Consulting	11,060						
McGladrey & Pullen	Accounting	2,500				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 179,084	TOTAL		TOTAL (agree to Sch. V, line 24, col. 8)		
						\$ 7,839		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												
2																									
3																									
4																									
5																									
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16																									
17																									
18																									
19																									
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greek American Rehab & Care Ctr# 0044149Report Period Beginning: 06/01/08Ending: 05/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$9,260 & ASHA \$200 & INHAA \$100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,171 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,690
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,202
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.