



Facility Name & ID Number Greek American Rehab & Nursing

# 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

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 12/1/2014

	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>198</u>	Skilled (SNF)	<u>188</u>	<u>70,450</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>198</u>	TOTALS	<u>188</u>	<u>70,450</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				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>11,768</u>		<u>6,507</u>	<u>18,275</u>	8
9	SNF/PED					9
10	ICF	<u>14,332</u>	<u>10,826</u>	<u>17,641</u>	<u>42,799</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,100</u>	<u>10,826</u>	<u>24,148</u>	<u>61,074</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.69%

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 188 and days of care provided 6,507

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 05/31/2015 Fiscal Year: 05/31/2015

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

Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

**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
	<b>A. General Services</b>										
1	Dietary	494,901	38,572	13,248	546,721		546,721		546,721		1
2	Food Purchase		464,922		464,922		464,922	(1,377)	463,545		2
3	Housekeeping	355,429	47,756	6,209	409,394		409,394		409,394		3
4	Laundry	162,053	5,740	3,931	171,724		171,724		171,724		4
5	Heat and Other Utilities			320,725	320,725		320,725	(7,468)	313,257		5
6	Maintenance	134,880	7,913	244,157	386,950		386,950	10,373	397,323		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,147,263	564,903	588,270	2,300,436		2,300,436	1,528	2,301,964		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	4,302,733	76,963	17,595	4,397,291		4,397,291		4,397,291		10
10a	Therapy	139,540	5,977	26,399	171,916		171,916		171,916		10a
11	Activities	197,987	15,059	3,430	216,476		216,476		216,476		11
12	Social Services	156,408	120	3,196	159,724		159,724		159,724		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,796,668	98,119	65,020	4,959,807		4,959,807		4,959,807		16
	<b>C. General Administration</b>										
17	Administrative	144,560			144,560		144,560		144,560		17
18	Directors Fees										18
19	Professional Services			130,645	130,645		130,645	(6,409)	124,236		19
20	Dues, Fees, Subscriptions & Promotions			49,292	49,292		49,292	(4,046)	45,246		20
21	Clerical & General Office Expenses	499,042	54,783	456,579	1,010,404		1,010,404	(319,142)	691,262		21
22	Employee Benefits & Payroll Taxes			1,407,611	1,407,611		1,407,611		1,407,611		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,110	17,110		17,110	(110)	17,000		24
25	Other Admin. Staff Transportation			1,235	1,235		1,235	(248)	987		25
26	Insurance-Prop.Liab.Malpractice			154,916	154,916		154,916	22,578	177,494		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	643,602	54,783	2,217,388	2,915,773		2,915,773	(307,377)	2,608,396		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,587,533	717,805	2,870,678	10,176,016		10,176,016	(305,849)	9,870,167		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.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			164,563	164,563		164,563	337,306	501,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,344	1,344		1,344	437,690	439,034			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			755,798	755,798		755,798	(748,621)	7,177			34
35	Rent-Equipment & Vehicles			11,951	11,951		11,951		11,951			35
36	Other (specify):*							55,063	55,063			36
37	<b>TOTAL Ownership</b>			933,656	933,656		933,656	81,438	1,015,094			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			7,318	7,318		7,318		7,318			38
39	Ancillary Service Centers	39,905	394,616	974,362	1,408,883		1,408,883		1,408,883			39
40	Barber and Beauty Shops			1,806	1,806		1,806	(1,806)	0			40
41	Coffee and Gift Shops	34,541		15,507	50,048		50,048	(32,041)	18,007			41
42	Provider Participation Fee			434,974	434,974		434,974		434,974			42
43	Other (specify):*	142,857		311,552	454,409		454,409	(454,409)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	217,303	394,616	1,745,519	2,357,438		2,357,438	(488,256)	1,869,182			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,804,836	1,112,421	5,549,853	13,467,110		13,467,110	(712,667)	12,754,443			45

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



Greek American Rehab & Nursing

ID# 0044149

Report Period Beginning: 06/01/14

Ending: 05/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (59,371)	21	1
2	Rebate Income	(1,842)	21	2
3	Telephone Income	(9,010)	21	3
4	Marketing Salary	(50,856)	43	4
5	Snack Shop Income	(32,041)	41	5
6	Marketing Expenses	(18,203)	43	6
7	Development Office Salaries	(92,001)	43	7
8	Bank Charges	(4,263)	21	8
9	Credit Card Fees	(4,378)	21	9
10	Employee Referral Fees	(1,728)	21	10
11	Meals	(18,599)	21	11
12	Flowers/Gifts	(8,131)	21	12
13	Barber & Beauty Expense	(1,806)	40	13
14	Unrealized Gains/Loss	(1,063)	21	14
15	Vending Machine Income	(345)	02	15
16	Employee Uniform Income	(12)	21	16
17	Misc. Income	(1,132)	21	17
18	Various Foundation Misc./Fundraising Expense	(293,350)	43	18
19	Bldg Co - Bank Charges	(450)	21	19
20	Bldg Co. Professional Fees	(13,500)	19	20
21	Bldg Co. Amortization	(1,833)	31	21
22	Non-Allowable Travel	(208)	25	22
23	Non-Allowable Seminars	(110)	24	23
24	Non-Allowable Legal Services	(6,409)	19	24
25	Capitallized R&M	(7,820)	06	25
26	Additional R&M	18,193	06	26
27	Transportation Income	(40)	25	27
28	PAC Dues	(4,424)	20	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	<b>Total</b>	(614,731)		49

Greek American Rehab & Nursing

Report Period Beginning:                     06/01/14                      
 Ending:   05/31/15  

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	<b>Total</b>		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15

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	(1,377)											(1,377)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,468)											(7,468)	5
6	Maintenance	10,373											10,373	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>1,528</b>											<b>1,528</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(19,909)	13,500										(6,409)	19
20	Fees, Subscriptions & Promotions	(4,424)	378										(4,046)	20
21	Clerical & General Office Expenses	(319,592)	450										(319,142)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(110)											(110)	24
25	Other Admin. Staff Transportation	(248)											(248)	25
26	Insurance-Prop.Liab.Malpractice		22,578										22,578	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(344,283)</b>	<b>36,906</b>										<b>(307,377)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(342,755)</b>	<b>36,906</b>										<b>(305,849)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14 Ending:

05/31/15

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(88,488)	425,794										337,306	30
31	Amortization of Pre-Op. & Org.	(1,833)	1,833											31
32	Interest	(17,080)	454,770										437,690	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(748,621)										(748,621)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		55,063										55,063	36
37	<b>TOTAL Ownership</b>	<b>(107,401)</b>	<b>188,839</b>										<b>81,438</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(1,806)											(1,806)	40
41	Coffee and Gift Shops	(32,041)											(32,041)	41
42	Provider Participation Fee													42
43	Other (specify):*	(454,409)											(454,409)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(488,256)</b>											<b>(488,256)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(938,412)</b>	<b>225,745</b>										<b>(712,667)</b>	<b>45</b>

**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
N/A		N/A		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.**  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	\$ 748,621	Hellenic American Care Foundation	100.00%	\$	(748,621)	1	
2	V	20 Dues & Subscriptions		Hellenic American Care Foundation	100.00%	378	378	2	
3	V	21 Bank Charges		Hellenic American Care Foundation	100.00%	450	450	3	
4	V	26 Insurance Expense		Hellenic American Care Foundation	100.00%	22,578	22,578	4	
5	V	36 MIP Expense		Hellenic American Care Foundation	100.00%	55,063	55,063	5	
6	V	32 Interest Expense		Hellenic American Care Foundation	100.00%	455,105	455,105	6	
7	V	19 Professional Fees		Hellenic American Care Foundation	100.00%	13,500	13,500	7	
8	V	30 Depreciation		Hellenic American Care Foundation	100.00%	425,794	425,794	8	
9	V	32 Interest Income	335	Hellenic American Care Foundation	100.00%		(335)	9	
10	V	31 Amortization		Hellenic American Care Foundation	100.00%	1,833	1,833	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 748,956			\$ 974,701	\$ *	225,745	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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:	
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)	
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	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										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 & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

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

Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending: 05/31/15

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

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing # 0044149 Report Period Beginning: 06/01/14 Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending: 05/31/15

**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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name &amp; ID Number

Greek American Rehab &amp; Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15

## 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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	HUD		X	Mortgage	\$47,833.38	9/1/2013	\$ 10,924,500	\$ 10,729,763	4/1/2051	4.2200	\$ 455,105	1								
2	Professional Building		X	Mortgage (Interest adj p. 5)				1,800,000				2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$47,833.38		\$ 10,924,500	\$ 12,529,763			\$ 455,105	9								
<b>B. Non-Facility Related*</b>																				
10	Bldg Co. Interest Income		X								(335)	10								
11	Interest & Dividend Income		X								(9,386)	11								
12	PA Interest Income		X								(7,694)	12								
13	See Supplemental Schedule										1,344	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (16,071)	14								
15	TOTALS (line 9+line14)						\$ 10,924,500	\$ 12,529,763			\$ 439,034	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 55,063 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 & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15	Other		X							1,344										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									1,344										

\* 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.)



# 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greek American Rehab & Nursing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044149

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

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

**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 a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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 & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15

**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:**

A. Land.

	1	2	3	4	
	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	<b>TOTALS</b>			<b>\$ 425,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	188		2001	\$ 11,639,080	\$ 425,794	40	\$ 290,977	\$ (134,817)	\$ 3,782,701	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		2001	58,125		20	2,906	2,906	34,248	9
10	Various		2003	16,264		20	813	813	10,299	10
11	Various		2005	3,121		20	156	156	1,560	11
12	Various		2006	51,393		20	2,570	2,570	24,980	12
13	Various		2007	696,321		20	34,291	34,291	289,556	13
14	Various		2008	137,791		20	3,766	3,766	27,217	14
15	Various		2009	108,881		20	10,176	10,176	24,106	15
16	Various		2010	32,439		20	8,571	8,571	5,834	16
17	Various		2011	17,496		20	1,411	1,411	5,777	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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67	<u>Related Building Company (Pages 12F &amp; 12G)</u>	243,993			12,200	12,200	64,727
68	<u>Related Party Allocations (Pages 12H &amp; 12I)</u>						
69	<u>Financial Statement Depreciation</u>		164,563			(164,563)	
70	<b>TOTAL (lines 4 thru 69)</b>	\$ 13,004,904	\$ 590,357		\$ 367,836	\$ (222,521)	\$ 4,271,005

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 13,004,904	\$ 590,357		\$ 367,836	\$ (222,521)	\$ 4,271,005	1
2	Panels, Rails, Cove Base; 2Nd & 3Rd Flr Tv Rms & Hallway	2012	6,050		20	252	252	1,008	2
3	Replace Transponder/Fire Alarm Repair	2012	4,380		20	219	219	657	3
4	Boiler Repair- Replaced 11 Tubes, Rear Firebox Wall, New Gaske	2012	4,343		20	217	217	651	4
5	Remove And Install Tile - 2Nd, 3Rd, 4Th Floor, Janitor Closets	2013	5,805		20	290	290	871	5
6	Electrical Work In Kitchen Panels	2013	3,209		20	160	160	321	6
7	Seal Coat & Restripe Parking Lot	2013	6,194		20	310	310	619	7
8	Canopy Light Fixtures	2015	2,620		20	131	131	131	8
9	Landscaping Brick Hollanstone	2015	5,200		20	260	260	260	9
10	Parking Lot Lights	2015	28,109		20	1,405	1,405	1,405	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	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		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	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		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	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)	\$ 13,070,814	\$ 590,357		\$ 371,081	\$ (219,276)	\$ 4,276,929	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Wanderguard System</b>	2008	85,666		20	4,283	4,283	29,981	9
10	<b>Security Cameras</b>	2008	50,000		20	2,500	2,500	17,500	10
11	<b>Cove base, flooring, tile, valves, pipes, showerhead, and drain</b>	2011	20,415		20	1,021	1,021	5,105	11
12	<b>Plumbing Replacements</b>	2012	5,000		20	250	250	1,000	12
13	<b>Laminate Flooring Installation</b>	2013	11,265		20	563	563	1,689	13
14	<b>Install Floor Tile-Houskeeping Director's Office, Physical Therapy</b>	2013	11,374		20	569	569	1,707	14
15	<b>Tile and Flooring</b>	2012	34,343		20	1,717	1,717	5,151	15
16	<b>Alpha Wing Guest Bath 1- Remove &amp; Install Tile, Sink, Faucet, Li</b>	2013	9,340		20	467	467	934	16
17	<b>Alpha Wing Guest Bath 2- Remove &amp; Install Tile, Sink, Faucet, Li</b>	2013	9,340		20	467	467	934	17
18	<b>Delta Wing - Guest Bath 3 - Remove &amp; Install Tile Sink, Faucet, L</b>	2013	7,250		20	363	363	726	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 243,993	\$		\$ 12,200	\$ 12,200	\$ 64,727	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 243,993	\$		\$ 12,200	\$ 12,200	\$ 64,727	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)	\$ 243,993	\$		\$ 12,200	\$ 12,200	\$ 64,727	34

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	Related Party		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Greek American Rehab & Nursing

# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15

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	\$ 1,332,515	\$	\$ 124,095	\$ 124,095	10	\$ 721,188	71
72	Current Year Purchases	29,246		2,925	2,925	10	2,925	72
73	Fully Depreciated Assets	1,225,839				10	1,220,926	73
74								74
75	TOTALS	\$ 2,587,600	\$	\$ 127,019	\$ 127,019		\$ 1,945,038	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		IBS Ford E450	2007	\$ 63,300	\$	\$ 3,768	\$ 3,768	5	\$ 33,912	76
77		Jeep Compass	2008	19,700				5	19,700	77
78										78
79										79
80	TOTALS			\$ 83,000	\$	\$ 3,768	\$ 3,768		\$ 53,612	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,166,414	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 590,357	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 501,869	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (88,488)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,275,579	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	Land - Professional Building	\$ 340,747	\$	\$	86
87	Land - Senior Center	87,598			87
88	Building - Professional Bldg	2,522,760			88
89	Building - Senior Center	788,386			89
90					90
91	TOTALS	\$ 3,739,491	\$	\$	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.

**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?  YES  NO

If NO, see instructions.

		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	Storage				7,177			5
6								6
7	TOTAL				\$ 7,177			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: \$ 11,951 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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

\* 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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	285,740	\$			\$	285,740	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						73,021					73,021	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs						593,982					593,982	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							228,819				228,819	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>				39,905				21,619	165,797				227,321	13	
14	TOTAL			\$	39,905			\$	974,362	\$	394,616		\$	1,408,883	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.

Facility Name & ID Number Greek American Rehab & Nursing# 0044149Report Period Beginning: 06/01/14Ending: 05/31/15

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/15

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 4,337,643	\$ 4,464,026	1
2	Cash-Patient Deposits	602,426	602,426	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	4,114,770	4,114,770	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2	2	6
7	Other Prepaid Expenses	3,501	28,124	7
8	Accounts Receivable (owners or related parties)		34,501	8
9	Other(specify):	1,425	623,159	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 9,059,767	\$ 9,867,008	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	428,345	853,345	13
14	Buildings, at Historical Cost	3,310,247	14,949,327	14
15	Leasehold Improvements, at Historical Cost	936,761	1,727,293	15
16	Equipment, at Historical Cost	1,095,740	2,672,033	16
17	Accumulated Depreciation (book methods)	(1,551,895)	(7,334,204)	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):		67,836	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,219,198	\$ 12,935,630	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,278,965	\$ 22,802,638	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 541,839	\$ 541,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	549,552	549,552	28
29	Short-Term Notes Payable	47,194	170,771	29
30	Accrued Salaries Payable	534,877	534,877	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,100	30,100	32
33	Accrued Interest Payable		37,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	37,057	37,057	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,740,619	\$ 1,901,928	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,752,806	12,358,992	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,752,806	\$ 12,358,992	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,493,425	\$ 14,260,920	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,785,540	\$ 8,541,718	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 13,278,965	\$ 22,802,638	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>7,009,941</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>AJE</u>	<u>320,045</u>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>7,329,986</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<u>2,455,554</u>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>2,455,554</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>9,785,540</b>	<b>24</b> *

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

Facility Name &amp; ID Number Greek American Rehab &amp; Nursing

# 0044149

Report Period Beginning: 06/01/14

Ending:

05/31/15

**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		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,941,872	1
2	Discounts and Allowances for all Levels	(5,202,518)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,739,354	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,559,037	6
7	Oxygen	6,930	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,565,967	8
<b>C. Other Operating Revenue</b>			
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	3,394	13
14	Non-Patient Meals	811	14
15	Telephone, Television and Radio	9,010	15
16	Rental of Facility Space	221	16
17	Sale of Drugs	332,297	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,333	19
20	Radiology and X-Ray		20
21	Other Medical Services	35,602	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 402,668	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	875,984	24
25	Interest and Other Investment Income***	17,080	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 893,064	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	1,321,611	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,321,611	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,922,664	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,300,436	31
32	Health Care	4,959,807	32
33	General Administration	2,915,773	33
<b>B. Capital Expense</b>			
34	Ownership	933,656	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,922,464	35
36	Provider Participation Fee	434,974	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,467,110	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,455,554	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,455,554	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,445,493	44
45	Private Pay - Net Inpatient Revenue	2,778,487	45
46	Medicare - Net Inpatient Revenue	1,367,104	46
47	Other-(specify) <u>ICP/Hospice</u>	148,270	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 10,739,354	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 & Nursing**

# **0044149**

Report Period Beginning:

**06/01/14**

Ending:

**05/31/15**

**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	2,306	2,562	\$ 116,392	\$ 45.43	1
2	Assistant Director of Nursing	123	123	4,535	36.87	2
3	Registered Nurses	51,371	58,673	1,667,854	28.43	3
4	Licensed Practical Nurses	15,500	18,136	467,334	25.77	4
5	CNAs & Orderlies	117,379	128,260	2,002,038	15.61	5
6	CNA Trainees					6
7	Licensed Therapist	1,435	1,594	39,905	25.03	7
8	Rehab/Therapy Aides	8,009	8,999	139,540	15.51	8
9	Activity Director	1,929	2,120	44,012	20.76	9
10	Activity Assistants	11,133	11,431	115,633	10.12	10
11	Social Service Workers	5,875	7,423	156,408	21.07	11
12	Dietician	2,018	2,080	47,834	23.00	12
13	Food Service Supervisor	3,191	3,469	97,586	28.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,863	29,520	349,481	11.84	15
16	Dishwashers					16
17	Maintenance Workers	5,501	5,979	134,880	22.56	17
18	Housekeepers	28,061	30,173	355,429	11.78	18
19	Laundry	12,621	13,869	162,053	11.68	19
20	Administrator	1,747	2,080	144,560	69.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,556	22,840	499,042	21.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,237	2,237	38,342	17.14	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,784	2,074	44,580	21.49	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,832	9,168	177,398	19.35	33
34	TOTAL (lines 1 - 33)	328,470	362,810	\$ 6,804,836 *	\$ 18.76	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	378	\$ 13,248	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,417	10-03	38
39	Pharmacist Consultant	Monthly	14,178	10-03	39
40	Physical Therapy Consultant	Monthly	26,399	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,430	11-03	44
45	Social Service Consultant	Monthly	3,196	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	378	\$ 78,268		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

**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		
Mark Murphey	Administrator	0	\$ 144,560	Workers' Compensation Insurance	\$ 176,229	IDPH License Fee	\$		
				Unemployment Compensation Insurance	36,927	Advertising: Employee Recruitment	6,349		
				FICA Taxes	488,721	Health Care Worker Background Check			
				Employee Health Insurance	615,206	(Indicate # of checks performed <u>367.8</u> )	3,678		
				Employee Meals		Patient Background Checks	<u>196</u> 1,960		
				Illinois Municipal Retirement Fund (IMRF)*		Bldg Co. Dues & Subscriptions	378		
				Insurance - Life, Dental, Vision, Disability	4,771	Dues/Memberships/Subscriptions	28,575		
				Employee Physicals	7,947	Taxes & Licenses	4,307		
				Employee Benefits	77,810				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>45,246</u>		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type	Amount				\$	Out-of-State Travel	\$	
See Attached	Legal	\$ 25,776							
Frost, Ruttenberg, & Rothblatt	Accounting	64,203							
Paycomm	Data Processing: Payroll	20,955							
Achieve Accreditation	Accreditation Consulting	13,629					In-State Travel		
Pinnacle Quality Insight	Client Satisfaction Cons.	4,178							
Personnel Planners	Unemployment Tax Consult	1,904							
							Seminar Expense	17,001	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 130,645	TOTAL			\$	TOTAL	\$ 17,001

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Greek American Rehab & Nursing# 0044149

Report Period Beginning:

06/01/14

Ending:

05/31/15**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 - \$12,289
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,395 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. \$ 434,974  
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 811
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Frost, Ruttenberg & Rothblatt, P.C.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.