

		FOR BHF USE					

LL 1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044149

Facility Name: Greek American Rehab Care Ct

Address: 220 North First St Wheeling 60090
Number City Zip Code

County: Cook

Telephone Number: (847) 459-8700 Fax #: (847) 465-9957

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2002

Type of Ownership:

X

VOLUNTARY, NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach, CPA Telephone Number: 847-628-8784
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 6/1/2024 to 5/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Effie Galetsis-Lalios

(Title) CFO

Paid Preparer

(Signed) 11/13/2025 (Date)

(Print Name and Title) Patrick McCormick Partner

(Firm Name & Address) Plante & Moran, PLLC 1111 Superior Ave Suite 1250 Cleveland, OH 44114

(Telephone) (216) 274-6524 Fax #: (248) 233-7349

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone #: (217) 782-1630

Facility Name & ID Number Greek American Rehab & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 <u>N/A</u>					
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	188	Skilled (SNF)	188	68,620	1
2	-	Skilled Pediatric (SNF/PED)	-	-	2
3	-	Intermediate (ICF)	-	-	3
4	-	Intermediate/DD	-	-	4
5	-	Sheltered Care (SC)	-	-	5
6	-	ICF/DD 16 or Less	-	-	6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	11,262	27,572			13,677	7,003	540	60,054	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	11,262	27,572			13,677	7,003	540	60,054	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 87.52%

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

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

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 4/1/2002

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 188

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: 5/31/2025 Fiscal Year: 5/31/2025
* All facilities other than governmental must report on the accrual basis.

	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	984,388	72,974	25,980	1,083,342		1,083,342		1,083,342			1
2	Food Purchase		622,069		622,069		622,069	(701)	621,368			2
3	Housekeeping	771,262	64,863	6,572	842,697		842,697		842,697			3
4	Laundry	103,291	25,591	7,865	136,747		136,747		136,747			4
5	Heat and Other Utilities			393,812	393,812		393,812	(17,124)	376,688			5
6	Maintenance	333,811	211,521		545,332		545,332	(9,794)	535,538			6
7	Other (specify):*			95,252	95,252		95,252		95,252			7
8	TOTAL General Services	2,192,752	997,018	529,481	3,719,251		3,719,251	(27,619)	3,691,632			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	8,155,854	435,480	5,627	8,596,961		8,596,961		8,596,961			10
10a	Therapy											10a
11	Activities	697,942	14,576	1,144	713,662		713,662		713,662			11
12	Social Services	246,709	710	45,721	293,140		293,140		293,140			12
13	CNA Training											13
14	Program Transportation			37,445	37,445		37,445	(3,428)	34,017			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	9,100,505	450,766	110,937	9,662,208		9,662,208	(3,428)	9,658,780			16
	C. General Administration											
17	Administrative	189,667		332,400	522,067		522,067		522,067			17
18	Directors Fees											18
19	Professional Services			301,653	301,653		301,653	(110)	301,543			19
20	Dues, Fees, Subscriptions & Promotions			86,246	86,246		86,246	(10,000)	76,246			20
21	Clerical & General Office Expenses	779,826	120,562	1,177,224	2,077,612		2,077,612	(1,156,509)	921,103			21
22	Employee Benefits & Payroll Taxes			2,535,454	2,535,454		2,535,454		2,535,454			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,288	8,288		8,288		8,288			24
25	Other Admin. Staff Transportation			13,374	13,374		13,374		13,374			25
26	Insurance-Prop.Liab.Malpractice			748,827	748,827		748,827	37,137	785,964			26
27	Other (specify):*											27
28	TOTAL General Administration	969,493	120,562	5,203,466	6,293,521		6,293,521	(1,129,482)	5,164,039			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	12,262,750	1,568,346	5,843,884	19,674,980		19,674,980	(1,160,529)	18,514,451			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.

5/31/2025

Auto and Travel Expense Detail

Date	General Ledger Accounts	Description of Expense	Employee	Employee Function	Location of Travel	Net Cost	Adjustments& Reclassifications	Final Expense
6/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	439.00		439.00
7/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
7/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
7/23/2025	54090-71	Travel reimbursement expenses	Denekos, Margarit	AP	Within Illinois - Around Wheeling, IL	305.07		305.07
7/24/2024	54090-71	Reimbursement Uber escorting	Naveja, Emily	CNN	Within Illinois - Around Wheeling, IL	63.81		63.81
7/30/2025	54090-71	Travel Leading Age seminar	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	23.30		23.30
8/1/2024	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
8/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
9/3/2024	54090-71	Reimbursement Uber escorting	Brito, Mayra	RN	Within Illinois - Around Wheeling, IL	36.84		36.84
9/1/2024	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
9/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
10/1/2024	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
10/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
11/1/2024	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
11/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	429.60		429.60
12/1/2024	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
12/1/2024	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	436.00		436.00
1/1/2025	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
1/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
2/1/2025	54090-71	Travel reimbursement expenses	Stamatoukos, Fran	Admission Director	Within Illinois - Around Wheeling, IL	22.40		22.40
2/1/2025	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
2/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
2/28/2025	54090-71	Travel reimbursement expenses	Stamatoukos, Fran	Admission Director	Within Illinois - Around Wheeling, IL	72.10		72.10
3/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
3/1/2025	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
4/1/2025	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	Hr	Within Illinois - Around Wheeling, IL	400.00		400.00
4/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
4/9/2025	54090-71	Travel reimbursement expenses	Stamatoukos, Fran	Admission Director	Within Illinois - Around Wheeling, IL	22.40		22.40
4/28/2025	54090-71	lpass autorelanishment			Within Illinois - Around Wheeling, IL	20.00		20.00
5/1/2025	54090-71	Travel reimbursement expenses	Joyal, Reesha	DON	Within Illinois - Around Wheeling, IL	716.66		716.66
5/1/2025	54090-71	Travel reimbursement expenses	Finkel, Mirdechai	HR	Within Illinois - Around Wheeling, IL	400.00		400.00
2/28/2025	504090-72	lpass autorelanishment- posted by mistake			Within Illinois - Around Wheeling, IL	20.00		20.00
Total						13,373.78	-	13,373.78

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			58,039	58,039		58,039	335,892	393,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							335,834	335,834			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			729,889	729,889		729,889	(726,024)	3,865			34
35	Rent-Equipment & Vehicles			38,434	38,434		38,434		38,434			35
36	Other (specify):*							50,638	50,638			36
37	TOTAL Ownership			826,362	826,362		826,362	(3,660)	822,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	145,968	218,826	726,724	1,091,518		1,091,518		1,091,518			39
40	Barber and Beauty Shops			1,410	1,410		1,410	(1,410)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,010,534	1,010,534		1,010,534		1,010,534			42
43	Other (specify):*			13,147	13,147		13,147	(13,147)				43
44	TOTAL Special Cost Centers	145,968	218,826	1,751,815	2,116,609		2,116,609	(14,557)	2,102,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	12,408,718	1,787,172	8,422,061	22,617,951		22,617,951	(1,178,746)	21,439,205			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,124)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,246)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,901)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(701)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(30,275)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,105,712)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(80,276)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,245,235)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	66,489	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 66,489		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,178,746)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044149

Report Period Beginning:6/1/2024

Ending:5/31/2025

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (10,000)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Building Company Misc Expense	(1,200)	21	3
4	Building Company Professional Fees	(11,499)	19	4
5	Building Company Legal Fees	(6,434)	19	5
6	Building Company Amortization	(1,833)	31	6
7	Non Allowable Rent Expense	(4,800)	34	7
8	Transportation Revenue	(3,428)	14	8
9	Telephone Income	(2,540)	21	9
10	Non-Allowable Legal Expense	(110)	19	10
11	Barber & Beauty Expenses	(1,410)	40	11
12	Other Marketing Costs	(13,147)	43	12
13	Bank Fees	(11,990)	21	13
14	Credit Card Fees	(2,091)	21	14
15	Capitalized R&M	(9,794)	6	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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	(80,276)		49

Summary A

Facility Name & ID Number	Greek American Rehab & Care Center	#	0044149	Report Period Beginning:	6/1/2024	Ending:	5/31/2025
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	(701)	-	-	-	-	-	-	-	-	-	-	(701)	2
3	Housekeeping	-	-	-	-	-	-	-	-	-	-	-	-	3
4	Laundry	-	-	-	-	-	-	-	-	-	-	-	-	4
5	Heat and Other Utilities	(17,124)	-	-	-	-	-	-	-	-	-	-	(17,124)	5
6	Maintenance	(9,794)	-	-	-	-	-	-	-	-	-	-	(9,794)	6
7	Other (specify):*	-	-	-	-	-	-	-	-	-	-	-	-	7
8	TOTAL General Services	(27,619)	-	-	-	-	-	-	-	-	-	-	(27,619)	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	(3,428)	-	-	-	-	-	-	-	-	-	-	(3,428)	14
15	Other (specify):*	-	-	-	-	-	-	-	-	-	-	-	-	15
16	TOTAL Health Care and Programs	(3,428)	-	-	-	-	-	-	-	-	-	-	(3,428)	16
	C. General Administration													
17	Administrative	-	-	-	-	-	-	-	-	-	-	-	-	17
18	Directors Fees	-	-	-	-	-	-	-	-	-	-	-	-	18
19	Professional Services	(18,043)	17,933	-	-	-	-	-	-	-	-	-	(110)	19
20	Fees, Subscriptions & Promotions	(10,000)	-	-	-	-	-	-	-	-	-	-	(10,000)	20
21	Clerical & General Office Expenses	(1,157,709)	1,200	-	-	-	-	-	-	-	-	-	(1,156,509)	21
22	Employee Benefits & Payroll Taxes	-	-	-	-	-	-	-	-	-	-	-	-	22
23	Inservice Training & Education	-	-	-	-	-	-	-	-	-	-	-	-	23
24	Travel and Seminar	-	-	-	-	-	-	-	-	-	-	-	-	24
25	Other Admin. Staff Transportation	-	-	-	-	-	-	-	-	-	-	-	-	25
26	Insurance-Prop.Liab.Malpractice	-	37,137	-	-	-	-	-	-	-	-	-	37,137	26
27	Other (specify):*	-	-	-	-	-	-	-	-	-	-	-	-	27
28	TOTAL General Administration	(1,185,752)	56,270	-	-	-	-	-	-	-	-	-	(1,129,482)	28
29	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,216,799)	56,270	-	-	-	-	-	-	-	-	-	(1,160,529)	29

Summary B

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

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership & 6-Supplemental Tabs		See Ownership & 6-Supplemental Tabs		See Ownership & 6-Supplemental Tabs		

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		
1	V	34	Rental Income	\$ 721,224	Hellenic American Care Foundation	100.00%	\$	(721,224)	1
2	V	32	Interest	4,102	Hellenic American Care Foundation	100.00%	347,182	343,080	2
3	V	26	Insurance Expense		Hellenic American Care Foundation	100.00%	37,137	37,137	3
4	V	36	MIP Expense		Hellenic American Care Foundation	100.00%	50,638	50,638	4
5	V	19	Professional Fees		Hellenic American Care Foundation	100.00%	11,499	11,499	5
6	V	19	Legal Expenses		Hellenic American Care Foundation	100.00%	6,434	6,434	6
7	V	30	Depreciation Expense		Hellenic American Care Foundation	100.00%	335,892	335,892	7
8	V	31	Amortization		Hellenic American Care Foundation	100.00%	1,833	1,833	8
9	V	21	Misc Expense		Hellenic American Care Foundation	100.00%	1,200	1,200	9
10	V								10
11	V	17	Admin Expenses & Salaries	332,400	Greek American Health Services Foundation	100.00%	332,400		11
12	V								12
13	V								13
14	Total			\$ 1,057,726			\$ 1,124,215	\$ * 66,489	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:	
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	Total			\$			\$ 0	\$ *	39

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

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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	Total			\$			\$ 0	\$ *	39

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

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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	Total			\$			\$ 0	\$ *	39

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

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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	Total			\$			\$ 0	\$ *	39

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

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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	Total			\$			\$ 0	\$ *	39

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

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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	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: 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	Total			\$			\$ 0	\$ *	39

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

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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	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: 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	Total			\$			\$ 0	\$ *	39

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

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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	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: 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	Total			\$			\$ 0	\$ *	39

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

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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	Total			\$			\$ 0	\$ *	39

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

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STATE OF ILLINOIS

Ownership Listing-2

Greek American Rehab & Care Center

ID#

0044149

Report Period Beginning:

6/1/2024

Ending:

5/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

First Name

M.I.

Last Name

Place of Residence

City

State

Operator/Licensee

Ownership

Percentage

Building Co.

Ownership

Percentage

Management

Co./Home Office

Ownership

Percentage

76

This schedule is N/A because the facility, building company, and management company are all non-profit entities

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VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	None		None		Hellenic American	Wheeling, Illinois	Building Co.	1
2					Care Foundation			2
3								3
4								4
5					Wheeling Professional	Wheeling, Illinois	Medical Bldg	5
6					Building, LLC			6
7								7
8								8
9					Paterakis Center, LTD	Wheeling, Illinois	Senior Center	9
10								10
11								11
12					Compassionate Love	Wheeling, Illinois	Day Care	12
13					Day Care			13
14								14
15								15
16					Greek American Health	Wheeling, Illinois	Parent Company	16
17					Services Foundation			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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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

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	See Listing of Board Members on Ownership-1										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

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									\$		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

Facility Name & ID Number Greek American Rehab & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

NO

X

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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

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	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
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Greek American Rehab & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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 & Care Center # 0044149 Report Period Beginning: 6/1/2024 Ending: 5/31/2025

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

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	HUD		X	Mortgage	\$44,979.93	9/1/2013	\$ 10,924,500	\$ 9,119,109	4/1/2052	3.7700	\$ 347,182	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$44,979.93		\$ 10,924,500	\$ 9,119,109			\$ 347,182	9	
	B. Non-Facility Related*												
10	Interest Income		X								(7,246)	10	
11	Interest Income- Bldg Co.		X								(4,102)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (11,348)	14	
15	TOTALS (line 9+line14)						\$ 10,924,500	\$ 9,119,109			\$ 335,834	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 50,638 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
N/A - facility is exempt from RE taxes				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

NOTES:

- 1 Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2 If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Greek American Rehab & Care Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0044149

CONTACT PERSON REGARDING THIS REPORT

Joshua S. Banach, CPA

TELEPHONE

847-628-8784

FAX #:

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2024 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2025 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2024.

Please complete the Real Estate Tax Statement below and include it in the 2025 cost report along with a copy of your 2024 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 524-4489.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Greek American Rehab & Care Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

44149

CONTACT PERSON REGARDING THIS REPORT

Joshua S. Banach, CPA

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,669

B. General Construction Type: Exterior BrickFrame 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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. 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

K. 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	Facility		1994	\$ 425,000	1
2					2
3	TOTALS			\$ 425,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	188			2001	\$ 11,639,080	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2001	58,125						9
10	Various			2003	16,264						10
11	Various			2005	3,121						11
12	Various			2006	51,393						12
13	Various			2007	696,321						13
14	Various			2008	137,791						14
15	Various			2009	108,881						15
16	Various			2010	32,439						16
17	Various			2011	17,496						17
18	Various			2012	14,773						18
19	Various			2013	15,208						19
20	Canopy - Light Fixtures			2015	2,620						20
21	Landscaping - Brick Hollanstone			2015	5,200						21
22	Parking Lot - Lights			2015	28,109						22
23	Conference Room Remodel - Wallpaper, Cove, Paint, and Trim			2016	7,200						23
24	Elevator Shaft - Pit Ladder Repacement			2016	5,910						24
25	Walk in Cooler - Shelving			2016	6,395						25
26	Boiler Room - Heating Pump			2017	5,364						26
27	Tiles for Front Hall			2018	4,462						27
28	Flagpole			2018	2,405						28
29	New exhaust roof			2018	5,513						29
30	Chapel Flooring			2018	3,156						30
31	Dining Room Remodel			2018	1,685						31
32	Exterior Canopy			2018	3,240						32
33	Elevator Area Remodel			2018	1,650						33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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	Remodel rooms 320-324; description below	2018	\$ 36,740	\$		\$	\$	\$	37
38	Millwork, flooring tile, bathroom tile								38
39	Remodel rooms 320-324; description below	2018	74,540						39
40	Flooring tile, wall finishing, fireplace area tiling								40
41	4th floor painting	2018	1,500						41
42	Upgrade elevator key pads on all four floors	2018	5,724						42
43	Remodel rooms 320-324; description below	2018	50,000						43
44	Wall and floor tile for resident rooms, window millwork								44
45	Compressor	2018	4,564						45
46									46
47	Main Air Cooler- HVAC System	2020	10,000						47
48	Main Air Cooler- HVAC System	2020	89,278						48
49	Main Air Cooler- HVAC Svsystem	2020	101,200						49
50	Office Renovation- Flooring, Walls, Tiling, Paint	2021	50,000						50
51	Office Renovation- Flooring, Walls, Tiling, Paint	2021	62,500						51
52	Office Renovation- Flooring, Walls, Tiling, Paint	2021	62,500						52
53	Secuirty Key Panel- Main Doors	2021	4,318						53
54	Nurse Call Light- Nurse Call System Through Facility	2021	14,154						54
55	Nurse Call Light- Nurse Call Svsystem Through Facility	2021	32,261						55
56									56
57	Installation of New LED Light Heads - Parking Lot	2021	2,639						57
58	New 751K BTU Hot Water Heater - Kitchen & Laundry	2022	19,650						58
59	Water Heater Repair- Heat Exchanger and Power Burner Repair	2022	3,041						59
60	Installation of Fountain System Within Exterior Pond	2022	3,213						60
61	Repair OfAMU Motor- Contactor and Fans- Boiler/Compressor	2022	6,976						61
62	Boiler Repair- Power To Gas Valve and Actuator - Boiler Room	2022	2,750						62
63	HVAC/AC Unit(s) Instal-SNF Area (Rooms, Commons, Office)	2022	9,825						63
64									64
65									65
66	Replace RH hot water storage tank with a new replacement tank	2023	2,612						66
67	Flooring and tiling repairs in kitchen	2023	2,750						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,526,536	\$		\$	\$	\$	70

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

XL 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	Totals from Page 12A, Carried Forward		\$ 13,526,536	\$		\$	\$	\$	1
2	Exterior Landscaping - Plant bulbs	2023	3,620						2
3	Exterior Landscaping - Replace wood chips	2023	3,240						3
4	Outdoor labor - tree trimming and remove pines/spruce	2023	3,892						4
5	Installation of new RH Storage Tank	2023	7,489						5
6	Replace INTELLIHOT Boiler	2023	5,328						6
7	Repair gazebo, columns courtyard era, paint	2023	4,500						7
8									8
9	Plank Flooring - Administrative Office	2024	3,708						9
10	1st Floor Hallway, Activity Room, Chapel- Wallpaper, Trim, Painting, B	2024	10,953						10
11	Church/Preparation Room - Wallpaper, Paint, Carpeting, Vinyl Floor	2024	4,500						11
12	Refacing, Repair, Painting of Gazebo on East Side of Facility	2024	3,000						12
13	Repairs to Compressor - Wiring & Control Unit (HVAC System)	2024	4,375						13
14	Replacement of Window in Administrative Office	2024	2,160						14
15	Bathroom Cabinets and Faucets in Administrative Offices	2024	3,598						15
16	Cabinets & Countertop With Piping - Kitchen/Coffee Shop of SNF	2024	5,350						16
17	Replacement of Barn Door - Sliding Glass in Admin Offices	2024	4,330						17
18	Addition of Roof & Gutter to Gazebo	2024	6,470						18
19	50 Gallon Electric Water Heater Replacement	2024	1,950						19
20	Repairs to Heating of the VAV System on the Boiler- Coils and Boxes	2024	7,227						20
21	IP Camera System with Wiring Throughout Facility	2024	3,845						21
22									22
23	Replace burner fan motor on portable water heater	2025	6,312						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)		\$ 13,622,383	\$		\$	\$	\$	34

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

XL OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 13,622,383	\$		\$	\$	\$	1
2	Hellenic American Care Foundation								2
3	Various	2008	135,666						3
4	Various	2011	20,415						4
5	Various	2012	39,343						5
6	Various	2013	48,569						6
7	Parking Lot - Paving	2016	66,261						7
8	Boiler Room - Hot Water Tank	2017	70,060						8
9	Flooring for Chapel	2018	2,450						9
10	Remodel room 319 - description below	2018	12,600						10
11	Framing, drywall, ceiling, plumbing, eletrical								11
12	Remodel room 319 - description below	2018	18,070						12
13	Eletrical, sprinkler system, paint, floor, tile, millwork								13
14	Renovation of room 319	2018	68,178						14
15	Room 313, 314, 320, 321, 322, 323, and 324 remodeling	2019	400,208						15
16	Video surveillance system throughout the SNF	2022	108,646						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	Depreciation - Greek American Rehab and Care Center, Inc			58,039		58,039		2,745,122	31
32	Depreciation - Hellenic American Care Foundation			335,892		335,892		9,301,139	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,612,849	\$ 393,931		\$ 393,931	\$	\$ 12,046,261	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	Totals from Page 12C, Carried Forward		\$ 14,612,849	\$ 393,931		\$ 393,931	\$	\$ 12,046,261	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
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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)		\$ 14,612,849	\$ 393,931		\$ 393,931	\$	\$ 12,046,261	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	Totals from Page 12D, Carried Forward		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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
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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)		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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	Totals from Page 12E, Carried Forward		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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	Totals from Page 12F, Carried Forward		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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	Totals from Page 12G, Carried Forward		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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
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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)		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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 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 12H, Carried Forward		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	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
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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)		\$14,612,849	\$393,931		\$393,931	\$	\$12,046,261	34

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

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	\$ 956,403	\$	\$	\$		\$	71
72	Current Year Purchases	41,689						72
73	Fully Depreciated Assets	180,558						73
74	See Attached					10		74
75	TOTALS	\$ 1,178,650	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	IBS Ford E4550	2007	\$ 63,300	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 63,300	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,279,799	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 393,931	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 393,931	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,046,261	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.

5/31/2025
Supplemental Schedule of Related Party Equipment

Current Year Purchases		Cost	Book Depreciation	SL Depreciation	Accumulated Depreciation
		-	-	-	-
Prior Year Purchases		Cost	Book Depreciation	SL Depreciation	Accumulated Depreciation
	-				
	-				
	-				
	-				
	-				
		-	-	-	-
Fully Depreciated Equipment		Cost	Book Depreciation	SL Depreciation	Accumulated Depreciation
	-				
	-				
	-				
	-				
	-				
		-	-	-	-
Total Equipment		Cost	Book Depreciation	SL Depreciation	Accumulated Depreciation
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
	-	-	-	-	-
		-	-	-	-

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 Unit				3,865			6
7	TOTAL				\$ 3,865			7

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	5/31/2026	\$
13	5/31/2027	\$
14	5/31/2028	\$

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: \$ 38,434
- Description: See Supplemental Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Greek American Rehab & Nursing
MOVABLE EQUIPMENT RENTAL
SUPPLEMENTAL SCHEDULE
06/01/2024-5/31/2025

Account Number	Make	Model Year	Monthly Lease Payment	Rental Expense for this Period
50000-50				2,565
		water cooler- June 2024- January, 2025	215.00	1,935
		February- May, 2025	210.00	630
41250-50				22,606
		Oxygen tanks		6,006
		Oxygen tanks from Advacare		200
		DVT Leg pump		8,028
		Bi-PAP		3,831
		C PAP auto		2,097
		O2 10 Liter concentrator		754
		Bariatric Walker+Comode		40
		Negative Pressure Machine		1,650
54090-50				13,263
		OmniSound Therapy system 6-12/2024	858.08	6,007
		OmniSound Therapy system 1-5/2025	875.24	4,376
		Quadent- Renting postage mashine		533
		Mother's Day Branch Rental		1,176
		Christmas Branch Rental		1,171
	TOTAL			38,434

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2 CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3 CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	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	V10A/V39	hrs	\$ 50,763	3,384	\$ 253,828	\$ -	3,384	\$ 304,591	1
2	Licensed Speech and Language Development Therapist	V10A/V39	hrs	22,065	925	69,378	-	925	91,443	2
3	Licensed Recreational Therapist	V10A/V39	hrs	-		-	-			3
4	Licensed Physical Therapist	V10A/V39	hrs	73,139	4,612	345,904	787	4,612	419,830	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39	# of prescrpts	-		-	214,254		214,254	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):	V39								12
13	Other (specify):	V39		-		57,614	3,785		61,399	13
14	TOTAL			\$ 145,968	8,921	\$ 726,724	\$ 218,826	8,921	\$ 1,091,518	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.

Greek American Rehab & Care Center
0044149
5/31/2025
Supplemental Schedule of Schedule XIV
Special Services - Line 13 Detail

Staffing - Scheudle XIV, Column 3		
Facility ACCOUNT NUMBER	Facility ACCOUNT NUMBER	BALANCE

Total Salaries	-
----------------	---

Supplies - Scheudle XIV, Column 6		
Facility ACCOUNT NUMBER	Facility ACCOUNT NUMBER	BALANCE
41250-60	Medical Supplies - Med A	3,785.00

Total Supplies	3,785.00
----------------	----------

Other Costs - Scheudle XIV, Column 5		
Facility ACCOUNT NUMBER	Facility ACCOUNT NUMBER	BALANCE
41350-60	radiology- medicare	20,260.00
41350-95	radiology - PA	350.00
41380-60	Lab- med A	37,004.00

Total Other Costs	57,614.00
-------------------	-----------

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	\$ 271,718	\$ 403,130	1
2	Cash-Patient Deposits	173,194	173,194	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance	1,529,257	1,529,257	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	285,567	307,916	6
7	Other Prepaid Expenses	117,262	117,262	7
8	Accounts Receivable (owners or related parties)	424,663	424,663	8
9	Other(specify): See Attached & TB	15,592	750,314	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,817,253	\$ 3,705,736	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	425,000	13
14	Buildings, at Historical Cost	1,620,940	13,260,020	14
15	Leasehold Improvements, at Historical Cost	-	1,464,711	15
16	Equipment, at Historical Cost	1,725,167	3,445,109	16
17	Accumulated Depreciation (book methods)	(2,816,824)	(12,198,658)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	70,891	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	-	(21,385)	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (see See Attached & TB	-	-	22
23	Other(specify): See Attached & TB	2,944,660	2,944,660	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,473,943	\$ 9,390,348	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,291,196	\$ 13,096,084	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 344,563	\$ 344,563	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	239,276	239,276	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	1,046,680	1,046,680	30
31	Accrued Taxes Payable (excluding real estate taxes)	-	-	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	-	32
33	Accrued Interest Payable	89,004	117,704	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Attached & TB	491,838	491,838	36
37	See Attached & TB	318,177	318,177	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,529,538	\$ 2,558,238	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	-	39
40	Mortgage Payable	-	9,119,109	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	See Attached & TB	2,790,457	2,790,457	43
44	See Attached & TB	-	-	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,790,457	\$ 11,909,566	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,319,995	\$ 14,467,804	46
47	TOTAL EQUITY(page 18, line 24)	\$ 971,201	\$ (1,371,720)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,291,196	\$ 13,096,084	48

*(See instructions.)

PG 17 Line 9 Detail		
CLIENT ACCOUNT NUMBER	CLIENT ACCOUNT DESCRIPTION	BALANCE
11900-00	Refunds Due/Clearing Acct.	7,861.00
11920-00	Trust Clearing Account	7,731.00
PM 11940.100	Insurance recoverable	550,000.00
11100 (CTB)	Insurance escrow	32,041.00
11120 (CTB)	Replacement reserve escrow	668,681.00
11300 (CTB)	MIP escrow	34,000.00
AJE	Due from Fundraising	(550,000.00)
Total		750,314.00

PG 17 Line 23 Detail		
CLIENT ACCOUNT NUMBER	CLIENT ACCOUNT DESCRIPTION	BALANCE
11905-00	Medicare receivable	(19,728.00)
13400-00	Capital deposit Trinity Risk	135,916.00
13500-00	deposits	300.00
PM 12552.100	Right to use asset	3,222,952.00
PM 12552.101	Right to use asset accum depreciation	(1,390,657.00)
PM 11290.100	Other Receivable	995,877.00
Total		2,944,660.00

PG 17 Line 36 Detail		
CLIENT ACCOUNT NUMBER	CLIENT ACCOUNT DESCRIPTION	BALANCE
PM 21203.100	Current portion of Right to use liability	(491,838.00)
Total		(491,838.00)

PG 17 Line 37 Detail		
CLIENT ACCOUNT NUMBER	CLIENT ACCOUNT DESCRIPTION	BALANCE
21010-00	accrued expenses - bed tax	(335,231.00)
21015-00	accrued expenses- other	8,339.00
21600-00	bcbs- upp	8,715.00
Total		(318,177.00)

PG 17 Line 43 Detail		
CLIENT ACCOUNT NUMBER	CLIENT ACCOUNT DESCRIPTION	BALANCE
12014-00	due from Bouras funds(GAF)	(900,000.00)
PM 21488.100	Accrued professional liability	(550,000.00)
PM 22630.100	Right to use liability	(1,340,457.00)
Total		(2,790,457.00)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,056,913	1
2	Restatements (describe):		2
3	Prior Year Journal Entries- Including Net Asset Transfers &	(1,132,788)	3
4	Adjustments to Bad Debt, Stimulus, and Provider Taxes		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 924,125	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,076	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)	\$ 47,076	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)	\$ 971,201	24 *

* This must agree with page 17, line 47.

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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 22,823,223	1
2	Discounts and Allowances for all Levels	(4,210,374)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,612,849	3
B. Ancillary Revenue			
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,985,050	6
7	Oxygen	-	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,985,050	8
C. Other Operating Revenue			
9	Payments for Education	-	9
10	Other Government Grants	-	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	-	13
14	Non-Patient Meals	-	14
15	Telephone, Television and Radio	2,540	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	179,277	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	33,655	19
20	Radiology and X-Ray	8,620	20
21	Other Medical Services	115,530	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 339,622	23
D. Non-Operating Revenue			
24	Contributions	400,010	24
25	Interest and Other Investment Income***	7,246	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 407,256	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached & TB	1,320,250	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,320,250	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 22,665,027	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,719,251	31
32	Health Care	9,662,208	32
33	General Administration	6,293,521	33
B. Capital Expense			
34	Ownership	826,362	34
C. Ancillary Expense			
35	Special Cost Centers	1,106,075	35
36	Provider Participation Fee	1,010,534	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,617,951	40
41	Income before Income Taxes (line 30 minus line 40)**	47,076	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 47,076	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 2,765,674	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,771,015	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	5,182,736	48
49	Medicare Part A	3,964,637	49
50	Other-(specify) Insurance, Managed Care	284,921	50
51	Other-(specify) Part B Revenues (no associated census days)	-356,134	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,612,849	56

PG 19 Line 28 Detail		
CLIENT ACCOUNT	ACCOUNT DESCRIPTION	BALANCE
33500-00	Transportation Income	(3,428.00)
47000-99	Rebate Income:	(3,901.00)
54090-96	Miscellaneous Expense	763.00
65105-00	Misc. Income	21,683.00
65209-00	QIP incentive	(133,307.00)
65210-00	C.N.A. initiative grant	(92,643.00)
PM 54199.100	ERC Income	(1,108,654.00)
AJE	Miscellaneous Expense	(763.00)
Total		(1,320,250.00)

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	1,929	2,052	\$ 160,144	\$ 78.05	1
2	Assistant Director of Nursing	2,117	2,252	127,725	56.71	2
3	Registered Nurses	57,563	61,238	2,993,523	48.88	3
4	Licensed Practical Nurses	26,306	27,985	1,241,470	44.36	4
5	CNAs & Orderlies	119,325	126,941	3,573,378	28.15	5
6	CNA Trainees			-		6
7	Licensed Therapist	2,764	2,941	145,968	49.63	7
8	Rehab/Therapy Aides			-		8
9	Activity Director	5,581	5,937	197,707	33.30	9
10	Activity Assistants	31,348	33,349	500,235	15.00	10
11	Social Service Workers	10,342	11,002	246,709	22.42	11
12	Dietician	2,243	2,386	71,093	29.80	12
13	Food Service Supervisor	2,726	2,900	86,409	29.80	13
14	Head Cook	15,963	16,982	475,594	28.01	14
15	Cook Helpers/Assistants	15,563	16,556	351,292	21.22	15
16	Dishwashers			-		16
17	Maintenance Workers	9,268	9,860	333,811	33.86	17
18	Housekeepers	31,893	33,928	771,262	22.73	18
19	Laundry	3,829	4,073	103,291	25.36	19
20	Administrator	2,109	2,243	189,667	84.56	20
21	Assistant Administrator			-		21
22	Other Administrative	19,214	20,440	779,826	38.15	22
23	Office Manager			-		23
24	Clerical			-		24
25	Vocational Instruction			-		25
26	Academic Instruction			-		26
27	Medical Director			-		27
28	Qualified ID Prof (QIDP)			-		28
29	Resident Services Coordinator			-		29
30	Habilitation Aides (DD Homes)			-		30
31	Medical Records	1,413	1,504	59,614	39.64	31
32	Other Health Care(specify)			-		32
33	Other(specify)			-		33
34	TOTAL (lines 1 - 33)	361,495	384,569	\$ 12,408,718 *	\$ 32.27	34

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	Monthly Fees	\$ 24,100	V01-3	35
36	Medical Director	Monthly Fees	21,000	V09-3	36
37	Medical Records Consultant		-		37
38	Nurse Consultant		-		38
39	Pharmacist Consultant		-		39
40	Physical Therapy Consultant	Monthly Fees	12,900	V39-3	40
41	Occupational Therapy Consultant		-		41
42	Respiratory Therapy Consultant		-		42
43	Speech Therapy Consultant		-		43
44	Activity Consultant	Monthly Fees	1,144	V11-3	44
45	Social Service Consultant	Monthly Fees	1,837	V12-3	45
46	Other(specify)		-		46
47			-		47
48	Pastoral Care	Monthly Fees	43,146	V12-3	48
49	TOTAL (lines 35 - 48)		\$ 104,127		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

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

** See instructions.

Facility Name & ID Number		Greek American Rehab & Care Center		STATE OF ILLINOIS		Report Period Beginning:		6/1/2024		Ending:		5/31/2025		
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			
Dino Varnavas		Administrator	0.00%	\$ 189,667	Workers' Compensation Insurance		\$ 225,604	IDPH License Fee			\$			
					Unemployment Compensation Insurance		13,078	Advertising: Employee Recruitment						
					FICA Taxes		879,647	Health Care Worker Background Check			874			
					Employee Health Insurance		1,108,476	(Indicate # of checks performed 87)						
					Employee Meals			Patient Background Checks			150 1,502			
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)			20,000			
					Employee 403B Plan Expense		8,669	Dues, Memberships & Subscriptions			62,697			
					Employee Awards		8,674	Taxes & Licenses			1,173			
					Uniforms		495							
					Employee Physicals		7,878							
					Holiday Party		15,587	Less: Public Relations Expense			()			
					Dental, Life, Vision & Disability Insurance		67,671	PAC and Lobbying payments			(10,000)			
					Other Employee Benefits		199,675	All non-allowable advertising			()			
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,535,454	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 76,246			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 189,667	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
B. Administrative - Other														
Description				Amount	Description		Line #	Amount	Description			Amount		
Greek American Health Services Foundation- Admin Fees				\$ 332,400				\$	Out-of-State Travel			\$		
									In-State Travel					
									Seminar Expense			8,288		
									Entertainment Expense			()		
									(agree to Sch. V, line 24, col. 8)					
									TOTAL			\$ 8,288		

* Attach copy of IMRF notifications

**See instructions.

Greek American Rehab & Care Center
0044149
5/31/2025
Detail of Legal Expense

General Ledger				Adjustments&		
Date	Accounts	Vendor	Description of Expense	Invoice Expense	Reclassifications	Final Expense
7/31/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	215.00		215.00
8/31/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	420.00		420.00
9/30/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	4,420.00		4,420.00
10/13/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	3,990.00		3,990.00
11/20/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	1,260.00		1,260.00
12/12/2024	54160-26	Hinshaw & Culbertson	Contest Medicare audits	5,310.00		5,310.00
1/31/2025	54160-26	Hinshaw & Culbertson	Contest Medicare audits	7,710.00		7,710.00
2/28/2025	54160-26	Hinshaw & Culbertson	Contest Medicare audits	4,442.00		4,442.00
4/1/2025	54160-26	Hinshaw & Culbertson	Contest Medicare audits	4,920.00		4,920.00
	54160-27	Schoenberg Finkel	Line of Credit Fees	110.00	(110.00)	-
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Greek American Rehab & Care Center
0044149
5/31/2025
Seminar Expense Detail

General Ledger						Adjustments&		Final Expense
Date	Accounts	Description of Expense	Employee	Employee Function	Location of Seminar	Net Cost	Reclassifications	
6/28/2024	41010-70	Leading Age seminars	Joyal, Reesha	DON	Schaumburg	399.00		399.00
6/28/2024	41010-70	Leading Age seminars	Chun, Diane	MDS	Schaumburg	399.00		399.00
6/28/2024	41010-70	Leading Age seminars	Dolma, Tsering	Restorative Nurse	Schaumburg	399.00		399.00
6/28/2024	41010-70	Leading Age seminars	Beri, Seroj	Restorative Nurse	Schaumburg	399.00		399.00
6/28/2024	41010-70	Leading Age seminars	Garcia, Warren	MDS	Schaumburg	399.00		399.00
7/28/2024	41010-70	Leading Age seminars	Sobey, Juliann	Infaction control nurse	Schaumburg	109.00		109.00
8/28/2024	41010-70	Leading Age seminars	Ojo, Jemi	Wound Care Nurse	Schaumburg	399.00		399.00
8/24/2025	41100-07	Mizpah CTR for Allied Health educ.	all new hires	CNN	Greek Home	1,000.00		1,000.00
9/28/2024	41100-07	Mizpah CTR for Allied Health educ.	all new hires	CNN	Greek Home	1,500.00		1,500.00
6/28/2024	54090-70	Leading Age seminars	Varnavas, Dino	Administrator	Schaumburg	399.00		399.00
6/28/2024	54090-70	Leading Age seminars	Finkel, Mordechai	HR	Schaumburg	399.00		399.00
7/28/2024	54090-70	CPA training	Lalios, Effie	CFO	On line	495.00		495.00
9/28/2024	54090-70	Seminars	Varnavas, Dino	Administrator	On line	249.00		249.00
#####	54090-70	Seminars	Varnavas, Dino	Administrator	On line	95.00		95.00
#####	54090-70	Legal Confecence- Hinshaw	Varnavas, Dino	Administrator	On line	99.92		99.92
2/28/2024	54090-70	Seminars	Varnavas, Dino	Administrator	On line	99.00		99.00
2/28/2024	54090-70	Ludas Medicare seminars	Strus, Luda	Biller	On line	99.00		99.00
2/28/2025	54090-70	Seminars	Diamond, Steffanie	Memory Care Director	On line	1,350.00		1,350.00
								-
								-
								-
								-
Total						8,287.92	-	8,287.92

XX. GENERAL INFORMATION:

- 1 Are nursing employees (RN,LPN,NA) represented by a union? No
- 2 Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|--------------------|---------------------|
| <u>Leading Age</u> | <u>10,000</u> |
| | |
| | |
| | <u>10,000</u> Total |
- 3 List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--------------------|---------------------|
| <u>Leading Age</u> | <u>10,000</u> |
| | |
| | |
| | <u>10,000</u> Total |
- 4 EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)
- | | |
|--------------------|---------------------|
| <u>Leading Age</u> | <u>20,000</u> |
| | |
| | |
| | <u>20,000</u> Total |
- 5 Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 76,347 Line 10-2
- 6 Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- 7 Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 1,010,534
This amount is to be recorded on line 42 of Schedule V.
- 8 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.

- 9 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
- 10 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.
- 11 Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- 12 Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A No
- 13 Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Plante & Moran PLLC
- 14 Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- 15 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.