



Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590 Report Period Beginning: 1/1/02 Ending: 12/31/02

**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 \_\_\_\_\_

	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	76	Skilled (SNF)	76	27,740	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	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	294	381		675	8
9	SNF/PED					9
10	ICF	15,912	6,312	245	22,469	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,206	6,693	245	23,144	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.43%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 2/22/75

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/02** Ending: **12/31/02**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	132,322	10,537	5,351	148,210		148,210		148,210		1
2	Food Purchase		96,207		96,207		96,207	(8,141)	88,066		2
3	Housekeeping	78,852	11,931		90,783		90,783	117	90,900		3
4	Laundry	21,968	10,485		32,453		32,453		32,453		4
5	Heat and Other Utilities			69,423	69,423		69,423		69,423		5
6	Maintenance	25,256	19,444	13,938	58,638		58,638	154	58,792		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	258,398	148,604	88,712	495,714		495,714	(7,870)	487,844		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	704,413	42,599	2,192	749,204	(3,976)	745,228		745,228		10
10a	Therapy		1,377	4,907	6,284		6,284		6,284		10a
11	Activities	32,328	4,196	2,505	39,029		39,029		39,029		11
12	Social Services	18,454		2,034	20,488		20,488		20,488		12
13	Nurse Aide Training			530	530		530		530		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	755,195	48,172	12,768	816,135	(3,976)	812,159		812,159		16
	<b>C. General Administration</b>										
17	Administrative	45,497			45,497		45,497	28,311	73,808		17
18	Directors Fees										18
19	Professional Services			148,855	148,855		148,855	(143,959)	4,896		19
20	Dues, Fees, Subscriptions & Promotions			8,298	8,298		8,298	(1,128)	7,170		20
21	Clerical & General Office Expenses	24,641	4,234	16,973	45,848		45,848	39,940	85,788		21
22	Employee Benefits & Payroll Taxes			148,035	148,035		148,035	8,626	156,661		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,677	2,677		2,677	2,698	5,375		24
25	Other Admin. Staff Transportation							156	156		25
26	Insurance-Prop.Liab.Malpractice			54,501	54,501		54,501	44	54,545		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	70,138	4,234	379,339	453,711		453,711	(65,312)	388,399		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,083,731	201,010	480,819	1,765,560	(3,976)	1,761,584	(73,182)	1,688,402		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.

Facility Name &amp; ID Number

BARRY COMMUNITY CARE CENTER

#0017590

Report Period Beginning:

1/1/02

Ending:

12/31/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			55,926	55,926		55,926		55,926			30
31	Amortization of Pre-Op. & Org.			9,917	9,917		9,917	(9,917)				31
32	Interest			113,729	113,729		113,729	(50,919)	62,810			32
33	Real Estate Taxes			39,475	39,475		39,475		39,475			33
34	Rent-Facility & Grounds							7,230	7,230			34
35	Rent-Equipment & Vehicles			202	202		202	2,346	2,548			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			219,249	219,249		219,249	(51,260)	167,989			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* LAB CONSULT/RX			165	165	3,976	4,141		4,141			43
44	<b>TOTAL Special Cost Centers</b>			41,775	41,775	3,976	45,751		45,751			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,083,731	201,010	741,843	2,026,584		2,026,584	(124,442)	1,902,142			45

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**

# **0017590**

Report Period Beginning: **1/1/02**

Ending: **12/31/02**

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,897)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,510)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(244)	2		13
14	Non-Care Related Interest	(49,409)	32		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	(273)	21		18
19	Entertainment	(38)	24		19
20	Contributions	(175)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(284)	20		28
29	Other-Attach Schedule SEE ATTACHED	(5,777)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (66,567)		\$	30

OHF 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	(9,917)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,958)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (57,875)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (124,442)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		3,976	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 3,976		47

**BARRY COMMUNITY CARE CENTER**

ID# 0017590

Report Period Beginning: 1/1/02

Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	RESIDENT SALES	\$ (5,463)	21	1
2	MISC INCOME	(314)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,777)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**# **0017590** Report Period Beginning:

1/1/02

Ending:

12/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,141)	0	0	0	0	0	0	0	0	0	0	(8,141)	2
3	Housekeeping	0	117	0	0	0	0	0	0	0	0	0	117	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	154	0	0	0	0	0	0	0	0	0	154	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,141)</b>	<b>271</b>	<b>0</b>	<b>(7,870)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	28,311	0	0	0	0	0	0	0	0	0	28,311	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(143,959)	0	0	0	0	0	0	0	0	0	(143,959)	19
20	Fees, Subscriptions & Promotions	(1,244)	116	0	0	0	0	0	0	0	0	0	(1,128)	20
21	Clerical & General Office Expenses	(6,225)	46,165	0	0	0	0	0	0	0	0	0	39,940	21
22	Employee Benefits & Payroll Taxes	0	8,626	0	0	0	0	0	0	0	0	0	8,626	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(38)	2,736	0	0	0	0	0	0	0	0	0	2,698	24
25	Other Admin. Staff Transportation	0	156	0	0	0	0	0	0	0	0	0	156	25
26	Insurance-Prop.Liab.Malpractice	0	44	0	0	0	0	0	0	0	0	0	44	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(7,507)</b>	<b>(57,805)</b>	<b>0</b>	<b>(65,312)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(15,648)</b>	<b>(57,534)</b>	<b>0</b>	<b>(73,182)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/02** Ending: **12/31/02**

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	(9,917)	0	0	0	0	0	0	0	0	0	0	(9,917) 31
32	Interest	(50,919)	0	0	0	0	0	0	0	0	0	0	(50,919) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	7,230	0	0	0	0	0	0	0	0	0	7,230 34
35	Rent-Equipment & Vehicles	0	2,346	0	0	0	0	0	0	0	0	0	2,346 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(60,836)</b>	<b>9,576</b>	<b>0</b>	<b>(51,260) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(76,484)</b>	<b>(47,958)</b>	<b>0</b>	<b>(124,442) 45</b>								

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	MAR-KA NURSING HOME	MASCOUTAH	COMMUNITY CARE	BALLWIN, MO	HOME OFFICE
		WEST MAIN NURSING HOME	MASCOUTAH	CENTERS, INC		
		MONMOUTH NURSING HOME	MASCOUTAH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 HOME OFFICE	\$ 145,500	COMMUNITY CARE CENTERS, INC	COMMON	\$	\$ (145,500) 1
2	V	34 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	7,230	7,230 2
3	V	35 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	2,346	2,346 3
4	V	17 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	28,311	28,311 4
5	V	21 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	46,165	46,165 5
6	V	22 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	8,626	8,626 6
7	V	19 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	1,541	1,541 7
8	V	24 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	2,736	2,736 8
9	V	25 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	156	156 9
10	V	6 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	154	154 10
11	V	20 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	116	116 11
12	V	26 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	44	44 12
13	V	3 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	117	117 13
14	Total		\$ 145,500			\$ 97,542	\$ * (47,958) 14

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/02** Ending: **12/31/02**

## 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	JAMES J GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	3	6.00	SALARY	\$ 22,893	17.7	1
2	DOROTHY GIARDINA	VICE PRES		0.00	NONE	3	6.00	SALARY	3,123	17.7	2
3	BETTY HUGHES	SECRETARY		0.00	NONE	2	4.35	SALARY	2,295	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 28,311		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 BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization COMMUNITY CARE CENTERS, CIN  
 Street Address 312 SOLLEY DRIVE - REAR  
 City / State / Zip Code BALLWIN, MO 63021  
 Phone Number ( 636-394-3000  
 Fax Number ( 636-394-7713

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19 HOME OFFICE	DIRECT COST			\$	\$		\$	1
2	WEST COUNTY CARE CTR						4,666,103	238,090	2
3	ST GENEVIEVE CARE CTR						2,146,567	109,532	3
4	CCC OF LEMAY						2,045,571	104,378	4
5	SALEM CARE CENTER						1,655,241	84,461	5
6	MONMOUTH NSG HOME						1,455,479	74,269	6
7	MAR-KA NSG HOME						2,278,751	116,277	7
8	WEST MAIN NSG HOME						1,005,118	51,287	8
9	CCC OF SENECA						2,501,431	127,639	9
10	MT VERNON PLACE CARE						2,418,329	123,398	10
11	COUNTRY VIEW NSG HOME						2,037,595	103,972	11
12	MERAMEC NSG HOME						1,257,168	64,149	12
13	SEVILLE CARE CENTER						2,254,668	115,050	13
14	SALEM RES CARE						448,556	22,887	14
15	BOSS RES CARE						130,198	6,644	15
16	CARL JUNCTION RES CARE						534,134	27,255	16
17	MT VERNON RES CARE						284,412	14,513	17
18	SENECA HOME PLACE						389,735	19,886	18
19	HUDSON HOUSE						407,567	20,798	19
20	MAPLE GROVE LODGE						2,182,418	111,362	20
21	SMITH BARR MANOR						739,700	37,745	21
22	CCC OF AURORA						3,702,560	188,929	22
23	BARRY COMMUNITY CARE						1,911,594	97,542	23
24	COMMUNITY IN HOME						270,328	13,793	24
25	TOTALS				\$	\$		\$ 1,873,856	25

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/02** Ending: **12/31/02**

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	FIRST NATL BANK OF BARRY	X	MORTGAGE	\$8,049.29	1/13/00	\$ 962,000		1/13/07	8.0000	\$ 63,457	1									
2											2									
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6	MISC INT - INS FINANCING	X								863	6									
7											7									
8											8									
9	TOTAL Facility Related			\$8,049.29		\$ 962,000				\$ 64,320	9									
	<b>B. Non-Facility Related*</b>																			
10	UNION PLANTERS BANK	X	STOCK BUYOUT	\$3,438.87	5/24/00	400,000		5/24/05	8.2500	27,595	10									
11	JOHN HUBBARD	X	STOCK BUYOUT	\$3,870.35	5/24/00	319,000		5/24/10	8.0000	21,814	11									
12											12									
13											13									
14	TOTAL Non-Facility Related			\$7,309.22		\$ 719,000				\$ 49,409	14									
15	TOTALS (line 9+line14)					\$ 1,681,000				\$ 113,729	15									

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

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

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**# **0017590** Report Period Beginning: **1/1/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2001 report.			\$	34,800	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.)			\$	39,475	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	4,675	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	34,800	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	39,475	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1997	28,568	8		
		1998	32,788	9		
		1999	34,631	10		
		2000	36,599	11		
		2001	39,475	12		
<b>ACCRUAL - SAME AS PRIOR YEAR</b>						
				<b>FOR OHF USE ONLY</b>		
		13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 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 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. 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 Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BARRY COMMUNITY CARE CENTER COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0017590

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: 636-394-7713

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

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>46-031-09</u>	<u>PP S SIDE NE</u>	\$ <u>39,474.52</u>	\$ <u>39,474.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>39,474.52</u>	\$ <u>39,474.52</u>

**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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER# 0017590 Report Period Beginning:1/1/02 Ending:12/31/02**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 28,930 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONEC. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>5.04 ACRES</u>	<u>1973</u>	<u>\$ 20,739</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>5.04 ACRES</u>		<u>\$ 20,739</u>	<u>3</u>

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning:

1/1/02

Ending:

12/31/02

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		Feb-75	1975	\$ 805,055	\$ 26,835	30	\$ 26,835	\$	\$ 742,312	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		PATIO		1976	936		20			936	9
10		DRIVE		1987	3,002	95	31	95		1,466	10
11		ROOF		1995	27,030	1,802	15	1,802		13,966	11
12		BLACKTOP DRIVE		1998	6,300	420	15	420		1,818	12
13		NEW CARPET - LIVING ROOM		2001	1,405	281	5	281		445	13
14		NEW CARPET		2001	1,497	299	5	299		474	14
15		NEW CEILING		2001	12,227	1,223	10	1,223		1,529	15
16		CARRIER ROOF TOP UNIT		2001	10,980	1,098	10	1,098		1,738	16
17		AIR HANDLER A/C FOR KITCHEN		2001	1,137	114	10	114		171	17
18		LIGHT FIXTURES, PAINT		2001	1,441	144	10	144		168	18
19		76 RESIDENT ROOM WALL BRACKET LIGHTS		2001	6,656	666	10	666		777	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 877,666	\$ 32,977		\$ 32,977	\$	\$ 765,800		70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 153,084	\$ 20,838	\$ 20,838	\$	3-10 YRS	\$ 73,253	71
72	Current Year Purchases	34,628	2,111	2,111		3-10 YRS	2,111	72
73	Fully Depreciated Assets	116,119				3-10 YRS	115,461	73
74								74
75	TOTALS	\$ 303,831	\$ 22,949	\$ 22,949	\$		\$ 190,825	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,202,236	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,926	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,926	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)	\$ 956,625	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	N/A	\$	\$	\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

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: \$ 202 Description: LP TANK RENTAL - 50, CONCRETE SAW RENTAL - 152  
 (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			\$ <u>N/A</u>	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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.

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$ 463	\$ 463
2	Books and Supplies			17	17
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests			50	50
9	<b>TOTALS</b>	\$	\$	\$ 530	\$ 530
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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	\$			\$			1	
2	Licensed Speech and Language Development Therapist		hrs										2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs										4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescrpts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	<b>TOTAL</b>			\$		\$	\$		\$		\$		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 nurse aides, who help with the above activities should not be listed on this schedule.**

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning: 1/1/02

Ending:

12/31/02

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 55,038	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	336,886		3
4 Supply Inventory (priced at COST )	2,050		4
5 Short-Term Investments			5
6 Prepaid Insurance	15,755		6
7 Other Prepaid Expenses	20,634		7
8 Accounts Receivable (owners or related parties)	702,136		8
9 Other(specify):			9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,132,499	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	20,739		13
14 Buildings, at Historical Cost	877,666		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	303,831		16
17 Accumulated Depreciation (book methods)	(951,624)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	53,884		19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(25,620)		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): DEPOSITS	1,000		23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 279,876	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,412,375	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 123,401	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	69,049		30
31 Accrued Taxes Payable (excluding real estate taxes)	5,019		31
32 Accrued Real Estate Taxes(Sch.IX-B)	34,800		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <b>DUE TO RELATED PARTIES</b>	206,376		36
37 <b>PT FUNDS PAY/UNEARNED INC</b>	65,687		37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 504,332	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	634,081		39
40 Mortgage Payable	773,260		40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <b>NON-COMPETE N/P</b>	17,500		43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,424,841	\$	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,929,173	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (516,798)	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,412,375	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(462,041)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(462,041)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(54,757)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(54,757)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(516,798)</b>	<b>24 *</b>

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning: 1/1/02

Ending:

12/31/02

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,919,414	1
2	Discounts and Allowances for all Levels	5,041	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,924,455	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,198	6
7	Oxygen	12,692	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 19,890	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,897	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,825	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,722	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,474	24
25	Interest and Other Investment Income***	1,510	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,984	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>RESIDENT SALES</b>	5,462	28
28a	<b>MISC INCOME</b>	314	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,776	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,971,827	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	495,714	31
32	Health Care	816,135	32
33	General Administration	453,711	33
<b>B. Capital Expense</b>			
34	Ownership	219,249	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	41,775	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,026,584	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(54,757)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (54,757)	43

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

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

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

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**# **0017590**Report Period Beginning: **1/1/02**Ending: **12/31/02**

## 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	1,853	\$ 45,012	\$ 21.64	1
2	Assistant Director of Nursing				2
3	Registered Nurses	9,185	167,335	17.31	3
4	Licensed Practical Nurses	7,132	89,893	12.03	4
5	Nurse Aides & Orderlies	44,650	392,184	8.30	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,822	17,126	8.76	9
10	Activity Assistants	2,130	15,202	6.47	10
11	Social Service Workers	1,872	18,454	9.08	11
12	Dietician				12
13	Food Service Supervisor	1,985	20,515	9.44	13
14	Head Cook				14
15	Cook Helpers/Assistants	7,807	57,163	6.98	15
16	Dishwashers	8,049	54,644	6.41	16
17	Maintenance Workers	1,943	25,256	11.22	17
18	Housekeepers	10,639	78,852	6.88	18
19	Laundry	2,857	21,968	7.16	19
20	Administrator	1,904	45,497	21.87	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	2,262	24,641	9.66	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	1,291	9,989	7.69	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	107,381	\$ 1,083,731 *	\$ 9.47	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 5,351	1.3	35
36	Medical Director	600	9.3	36
37	Medical Records Consultant	368	10.3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	96	10.3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	31	11.3	44
45	Social Service Consultant	31	12.3	45
46	Other(specify)	2	43.3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,261		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTH CARE ASSOC - \$4,131
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 3-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,610  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
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? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.