

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** 0017590

**Facility Name:** BARRY COMMUNITY CARE CENTER

**Address:** 1313 PRATT STREET BARRY 62312  
 Number City Zip Code

**County:** PIKE

**Telephone Number:** ( 217 ) 335-5326 Fax # ( 217 ) 335-7031

**HFS ID Number:** 370990780001

**Date of Initial License for Current Owners:** 1975

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** YVONNE CHUA **Telephone Number:** ( 636 ) 394-3000

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/07 to 12/31/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JAMES J GIARDINA</u>	
	(Title) <u>PRESIDENT</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>PO BOX 1190; SPRINGFIELD, MO 65801-1190</u>	
	(Telephone) <u>( 417 ) 865-8701</u> Fax # <u>(417) 865-0682</u>	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590 Report Period Beginning: 1/1/07 Ending: 12/31/07

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,354	9,595	1,600	24,549	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,354	9,595	1,600	24,549	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.50%

D. How many bed-hold days during this year were paid by the Department?

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 76 and days of care provided 1,589

Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/07** Ending: **12/31/07**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	151,764	14,160	4,485	170,409		170,409		170,409		1
2	Food Purchase		114,360		114,360		114,360	(8,528)	105,832		2
3	Housekeeping	112,609	12,819		125,428		125,428	165	125,593		3
4	Laundry	18,780	17,941		36,721		36,721		36,721		4
5	Heat and Other Utilities			88,948	88,948		88,948		88,948		5
6	Maintenance	42,235	18,857	28,549	89,641		89,641	337	89,978		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>325,388</b>	<b>178,137</b>	<b>121,982</b>	<b>625,507</b>		<b>625,507</b>	<b>(8,026)</b>	<b>617,481</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	976,882	86,907	4,848	1,068,637		1,068,637		1,068,637		10
10a	Therapy		865	277,591	278,456		278,456		278,456		10a
11	Activities	21,278	6,913	1,887	30,078		30,078		30,078		11
12	Social Services	25,610	2	1,887	27,499		27,499		27,499		12
13	CNA Training			750	750		750		750		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,023,770</b>	<b>94,687</b>	<b>292,963</b>	<b>1,411,420</b>		<b>1,411,420</b>		<b>1,411,420</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	54,520			54,520		54,520	9,101	63,621		17
18	Directors Fees										18
19	Professional Services			206,502	206,502		206,502	(195,861)	10,641		19
20	Dues, Fees, Subscriptions & Promotions			11,816	11,816		11,816	(1,612)	10,204		20
21	Clerical & General Office Expenses	25,307	6,467	22,104	53,878		53,878	43,734	97,612		21
22	Employee Benefits & Payroll Taxes			228,014	228,014		228,014	6,049	234,063		22
23	Inservice Training & Education			175	175		175		175		23
24	Travel and Seminar			7,158	7,158		7,158	2,770	9,928		24
25	Other Admin. Staff Transportation							335	335		25
26	Insurance-Prop.Liab.Malpractice			52,781	52,781		52,781	43	52,824		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>79,827</b>	<b>6,467</b>	<b>528,550</b>	<b>614,844</b>		<b>614,844</b>	<b>(135,441)</b>	<b>479,403</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,428,985</b>	<b>279,291</b>	<b>943,495</b>	<b>2,651,771</b>		<b>2,651,771</b>	<b>(143,467)</b>	<b>2,508,304</b>		<b>29</b>

\*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 & ID Number BARRY COMMUNITY CARE CENTER #0017590 Report Period Beginning: 1/1/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			46,890	46,890		46,890		46,890		30
31	Amortization of Pre-Op. & Org.			740	740		740		740		31
32	Interest			106,928	106,928		106,928	(3,911)	103,017		32
33	Real Estate Taxes			51,977	51,977		51,977		51,977		33
34	Rent-Facility & Grounds							9,570	9,570		34
35	Rent-Equipment & Vehicles			564	564		564	2,746	3,310		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			207,099	207,099		207,099	8,405	215,504		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			12,057	12,057		12,057		12,057		43
44	<b>TOTAL Special Cost Centers</b>			53,667	53,667		53,667		53,667		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,428,985	279,291	1,204,261	2,912,537		2,912,537	(135,062)	2,777,475		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: **1/1/07**

Ending: **12/31/07**

**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	(8,307)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,911)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(221)	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	(1,213)	21		18
19	Entertainment	(321)	24		19
20	Contributions	(1,847)	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	(1,891)	20		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	(9,422)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (27,133)		\$	30

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)	(107,929)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (107,929)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (135,062)		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		44,659	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>			\$ 44,659		47

BHF USE ONLY						
48		49		50		51
						52

**BARRY COMMUNITY CARE CENTER**

ID# 0017590

Report Period Beginning: 1/1/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	TRAVEL CHGD TO RESIDENTS	\$ (392)	24	1
2	RESIDENT SALES	(2,780)	21	2
3	MISC INCOME - HEALTH INS REFUND	(3,140)	22	3
4	MISC INCOME	(3,110)	21	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>	(9,422)		49

STATE OF ILLINOIS

Summary A

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

# **0017590**

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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	(8,528)	0	0	0	0	0	0	0	0	0	0	(8,528)	2
3	Housekeeping	0	165	0	0	0	0	0	0	0	0	0	165	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	337	0	0	0	0	0	0	0	0	0	337	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,528)</b>	<b>502</b>	<b>0</b>	<b>(8,026)</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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<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	9,101	0	0	0	0	0	0	0	0	0	9,101	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(195,861)	0	0	0	0	0	0	0	0	0	(195,861)	19
20	Fees, Subscriptions & Promotions	(1,891)	279	0	0	0	0	0	0	0	0	0	(1,612)	20
21	Clerical & General Office Expenses	(8,950)	52,684	0	0	0	0	0	0	0	0	0	43,734	21
22	Employee Benefits & Payroll Taxes	(3,140)	9,189	0	0	0	0	0	0	0	0	0	6,049	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(713)	3,483	0	0	0	0	0	0	0	0	0	2,770	24
25	Other Admin. Staff Transportation	0	335	0	0	0	0	0	0	0	0	0	335	25
26	Insurance-Prop.Liab.Malpractice	0	43	0	0	0	0	0	0	0	0	0	43	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(14,694)</b>	<b>(120,747)</b>	<b>0</b>	<b>(135,441)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(23,222)</b>	<b>(120,245)</b>	<b>0</b>	<b>(143,467)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning:

1/1/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,911)	0	0	0	0	0	0	0	0	0	0	(3,911)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,570	0	0	0	0	0	0	0	0	0	9,570	34
35	Rent-Equipment & Vehicles	0	2,746	0	0	0	0	0	0	0	0	0	2,746	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,911)</b>	<b>12,316</b>	<b>0</b>	<b>8,405</b>	<b>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</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(27,133)</b>	<b>(107,929)</b>	<b>0</b>	<b>(135,062)</b>	<b>45</b>								

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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	BALLWIN, MO	HOME OFFICE
		MONMOUTH NURSING HOME	MASCOUTAH	CARE CENTERS, INC		
				RISA	JEFFERSON CITY, MO	W/C INS
				RISA	JEFFERSON CITY, MO	LIAB INS

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	\$ 198,000	COMMUNITY CARE CENTERS, INC	COMMON	\$	\$ (198,000) 1
2	V	34 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	9,570	9,570 2
3	V	35 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	2,746	2,746 3
4	V	17 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	9,101	9,101 4
5	V	21 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	52,684	52,684 5
6	V	22 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	9,189	9,189 6
7	V	19 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	2,139	2,139 7
8	V	24 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	3,483	3,483 8
9	V	25 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	335	335 9
10	V	6 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	337	337 10
11	V	20 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	279	279 11
12	V	26 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	43	43 12
13	V	3 HOME OFFICE		COMMUNITY CARE CENTERS, INC	COMMON	165	165 13
14	Total		\$ 198,000			\$ 90,071	\$ * (107,929) 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: **1/1/07**

Ending: **12/31/07**

**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	22 WORKERS COMP INS	\$ 66,154	RISA	25.00%	\$ 66,154	\$
16	V	26 LIABILITY INS	45,814	RISA	25.00%	45,814	
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 111,968			\$ 111,968	\$ *

\* 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: 1/1/07 Ending: 12/31/07

## 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	\$ 5,472	19.3	1
2	BETTY HUGHES	SECRETARY		0.00	NONE	2	5.00	SALARY	3,629	19.3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,101		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: 1/1/07

Ending: 12/31/07

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

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	19	HOME OFFICE	DIRECT COST		\$	\$		\$	1
2		WEST COUNTY CARE CENTER					5,307,567		2
3		ST GENEVIEVE CARE CTR					2,545,616		3
4		CCC OF LEMAY					2,462,676		4
5		SALEM CARE CENTER					1,293,013		5
6		MONMOUTH NH					2,239,866		6
7		MAR-KA NH					2,984,003		7
8		CCC OF SENECA					2,816,361		8
9		MT VERNON PLACE CARE					2,686,003		9
10		COUNTRY VIEW NH					2,150,970		10
11		MERAMEC NH					2,640,508		11
12		SEVILLE CARE CENTER					2,871,893		12
13		SALEM RES CARE					576,113		13
14		CARL JUNCTION RES CARE					655,589		14
15		MT VERNON RES CARE					516,335		15
16		SENECA HOME PLACE					510,546		16
17		HUDSON HOUSE					530,685		17
18		MAPLE GROVE LODGE					2,856,567		18
19		CCC OF AURORA					4,674,522		19
20		BARRY COMMUNITY CARE					2,709,134		20
21		LICKING RESIDENTIAL CTR					402,131		21
22		CCC OF GAINESVILLE					2,415,594		22
23		AL OF SILVER CREEK					342,585		23
24		COMMUNITY IN HOME					846,367		24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/07** Ending: **12/31/07**

**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	Name of Lender	2		3	4	5	6		8	9	10						
		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 NAT'L BANK OF BARRY	X		MORTGAGE-REFINANCE	\$11,632.51	9/6/05	\$ 1,500,000	\$ 1,415,809	9/6/08	7.0000	\$ 100,603	1					
2	GE COMMERCIAL FINANCE	X		FIRE ALARM SYSTEM	\$573.51	1/10/07	23,455	18,656	5/2/07	4.2500	1,282	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	FIRST NAT'L BANK OF BARRY	X		WORKING CAP-LOC				199,000		VAR	5,037	6					
7	MISC INTEREST	X									6	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$12,206.02		\$ 1,523,455	\$ 1,633,465			\$ 106,928	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,523,455	\$ 1,633,465			\$ 106,928	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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: **1/1/07**

Ending: **12/31/07**

**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 2006 report.		\$	<b>34,800</b>	<b>1</b>
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.)		\$	<b>51,977</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>17,177</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>34,800</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>51,977</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<b>40,940</b>	<b>8</b>	
	2003	<b>43,142</b>	<b>9</b>	
	2004	<b>46,638</b>	<b>10</b>	
	2005	<b>48,796</b>	<b>11</b>	
	2006	<b>51,977</b>	<b>12</b>	
<b>ACCRUAL - SAME AS PRIOR YEAR</b>				

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

**2006 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 2006 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 2006.

(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>RNG/BLK:6 TWP:04 SECT/LOT:25</u>	<u>\$ 51,977.00</u>	<u>\$ 51,977.00</u>
2. _____	<u>PT S SIDE NE</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	<b>TOTALS</b>	<u>\$ 51,977.00</u>	<u>\$ 51,977.00</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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590 Report Period Beginning:

1/1/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,930 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

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).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**# **0017590**

Report Period Beginning:

**1/1/07**

Ending:

**12/31/07****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		Feb-75	1975	\$ 805,055	\$	30	\$	\$	\$ 805,055	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		1,943	10
11	ROOF			1995	27,030	1,802	15	1,802		22,976	11
12	BLACKTOP DRIVE			1998	6,300	420	15	420		3,918	12
13	NEW CEILING			2001	12,227	1,223	10	1,223		7,642	13
14	CARRIER ROOF TOP UNIT			2001	10,980	1,098	10	1,098		7,228	14
15	AIR HANDLER A/C FOR KITCHEN			2001	1,137	114	10	114		739	15
16	LIGHT FIXTURES, PAINT			2001	1,441	144	10	144		888	16
17	76 RESIDENT ROOM WALL BRACKET LIGHTS			2001	6,656	666	10	666		4,105	17
18	FIRE ALARM SYSTEM DISPOSAL 2007			2004		1,502	10	1,502			18
19	AMER STANDARD 15T RFTOP A/C			2004	11,475	1,147	10	1,147		4,208	19
20	FIRE SUPPRESSION SYSTEM DISPOSAL 2007			2005		1,604	10	1,604			20
21	85-GALLON WATER HEATER			2005	5,016	502	10	502		1,254	21
22	CARPET-FOYER, OFFICES			2005	5,373	1,075	5	1,075		2,418	22
23	TILE FLOORING DIN RM, LV RM			2005	5,598	560	10	560		1,260	23
24	PAINTING			2005	15,490	1,549	10	1,549		3,098	24
25	WAINSCOTING			2005	4,187	418	10	418		837	25
26	CEILING LIGHT FIXTURES			2005	1,121	112	10	112		224	26
27	WALLPAPER			2005	8,958	896	10	896		1,792	27
28	OUTDOOR LIGHTS			2005	1,188	119	10	119		238	28
29	LANDSCAPING			2005	7,080	708	10	708		1,534	29
30	BRICK SIGN			2005	4,895	489	10	489		1,020	30
31	CONCRETE WORK			2005	1,931	129	15	129		268	31
32	LANDSCAPING			2006	1,020	102	10	102		204	32
33	CONCRETE WORK			2006	4,625	308	15	308		334	33
34	RE-ROOF FRONT ENTRANCE			2006	1,592	159	10	159		318	34
35	HALL LIGHTS			2006	994	99	10	99		199	35
36	NEW WINDOWS			2006	2,172	217	10	217		416	36

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

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

See Page 12A, Line 70 for total

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

# **0017590**

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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	NEW WINDOWS	2006	\$ 2,264	\$ 226	10	\$ 226	\$	\$ 321	37
38	FLOORING DINING ROOM	2006	3,677	368	10	368		735	38
39	SS WALLCOVERING BEHIND STOVE	2006	1,408	282	5	282		352	39
40	FIREPROOFING & FIREWALLS	2006	1,900	380	5	380		412	40
41	FIRE ALARM SYSTEM	2007	23,455	2,346	10	2,346		2,346	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	TOTAL (lines 4 thru 69)		\$ 990,183	\$ 20,859		\$ 20,859	\$	\$ 879,218	70

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 284,483	\$ 21,125	\$ 21,125	\$	VAR	\$ 184,691	71
72	Current Year Purchases	1,738	112	112		VAR	112	72
73	Fully Depreciated Assets	125,471					124,813	73
74								74
75	TOTALS	\$ 411,692	\$ 21,237	\$ 21,237	\$		\$ 309,616	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	2003 CHEVY SAVANA	2003	4/18/2004	\$ 19,175	\$ 4,794	\$ 4,794	\$	4	\$ 17,976	76
77										77
78										78
79										79
80	TOTALS			\$ 19,175	\$ 4,794	\$ 4,794	\$		\$ 17,976	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 1,441,789	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,890	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,890	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)	\$ 1,206,810	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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					_____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 564 Description: LP TANK \$50; STORAGE UNIT \$450; JACK HAMMER \$64

(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	<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.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/07 Ending: 12/31/07

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>85</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>42</u></p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 750	\$	\$ 750
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	\$	\$ 750	\$	\$ 750
10	SUM OF line 9, col. 1 and 2 (e)	\$	750		

**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	<u>1</u>
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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	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	10a	hrs	\$	1,522	\$ 104,413	\$ 692	1,522	\$ 105,105	1
2	Licensed Speech and Language Development Therapist	10a	hrs		237	16,213		237	16,213	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		2,440	156,965	173	2,440	157,138	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>			\$	4,199	\$ 277,591	\$ 865	4,199	\$ 278,456	14

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

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

# **0017590**

Report Period Beginning: **1/1/07**

Ending:

**12/31/07**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/07**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (28,637)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	562,072		3
4	Supply Inventory (priced at <u>COST</u> )	2,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,796		6
7	Other Prepaid Expenses	22,969		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>	\$ 1,276,386	\$	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	990,183		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	430,867		16
17	Accumulated Depreciation (book methods)	(1,201,811)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	53,884		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(51,315)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>DEPOSITS</u>	1,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 243,547	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,519,933	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 853,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	199,000		29
30	Accrued Salaries Payable	88,308		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,088		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	<u>DUE TO RELATED PARTIES</u>	295,876		36
37	<u>PT FUNDS/UNEARNED INCOME</u>	144,533		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,626,156	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	18,656		39
40	Mortgage Payable	1,415,809		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,434,465	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,060,621	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,540,688)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,519,933	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(842,050)</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>(842,050)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>210,068</b>	<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>(900,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PRIOR YEAR ADJUSTMENT</b>	<b>(8,706)</b>	<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>(698,638)</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>(1,540,688)</b>	<b>24</b> *

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER# 0017590Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 13,657,425	1
2	Discounts and Allowances for all Levels	(11,244,147)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,413,278	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	583,286	6
7	Oxygen	104,401	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 687,687	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,307	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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>	\$ 8,307	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,911	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,911	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Resident Sales 2,780; Tvl-Residents 392	3,172	28
28a	Health Ins Refund 3,140; Misc Inc 3,110	6,250	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,422	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,122,605	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	625,507	31
32	Health Care	1,411,420	32
33	General Administration	614,844	33
<b>B. Capital Expense</b>			
34	Ownership	207,099	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,057	35
36	Provider Participation Fee	41,610	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,912,537	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	210,068	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 210,068	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:

1/1/07

Ending:

12/31/07

**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	1,842	2,080	\$ 49,153	\$ 23.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,642	6,006	125,947	20.97	3
4	Licensed Practical Nurses	16,266	17,225	247,381	14.36	4
5	CNAs & Orderlies	54,572	57,648	538,226	9.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,935	2,119	21,278	10.04	9
10	Activity Assistants					10
11	Social Service Workers	1,910	2,172	25,610	11.79	11
12	Dietician					12
13	Food Service Supervisor	1,610	1,936	20,619	10.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,256	7,540	62,083	8.23	15
16	Dishwashers	8,446	8,738	69,062	7.90	16
17	Maintenance Workers	4,145	4,329	42,235	9.76	17
18	Housekeepers	12,782	13,522	112,609	8.33	18
19	Laundry	1,998	2,206	18,780	8.51	19
20	Administrator	1,828	2,080	54,520	26.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,972	2,166	25,307	11.68	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	1,586	1,618	16,175	10.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,790	131,385	\$ 1,428,985 *	\$ 10.88	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	118	\$ 4,348	1.3	35
36	Medical Director	96	6,000	9.3	36
37	Medical Records Consultant	48	2,430	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	2,418	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	22	1,887	11.3	44
45	Social Service Consultant	22	1,887	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 18,970		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





Facility Name & ID Number BARRY COMMUNITY CARE CENTER# 0017590Report Period Beginning: 1/1/07Ending: 12/31/07**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 \$4,195
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (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. \$ 257 Line 10.2
- (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 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, 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? 73%  
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: \_\_\_\_\_ 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 \$5,000, 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.