



Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590 Report Period Beginning: 1/1/08 Ending: 12/31/08

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	27,816	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	27,816	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	12,717	9,103	2,586	24,406	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,717	9,103	2,586	24,406	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.74%

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)

N/A

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 2,584

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/08** Ending: **12/31/08**

**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	163,708	16,254	4,026	183,988		183,988		183,988		1
2	Food Purchase		122,855		122,855		122,855	(7,685)	115,170		2
3	Housekeeping	104,164	14,384		118,548		118,548	160	118,708		3
4	Laundry	31,547	19,942		51,489		51,489		51,489		4
5	Heat and Other Utilities			94,014	94,014		94,014		94,014		5
6	Maintenance	22,500	23,190	16,604	62,294		62,294	208	62,502		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>321,919</b>	<b>196,625</b>	<b>114,644</b>	<b>633,188</b>		<b>633,188</b>	<b>(7,317)</b>	<b>625,871</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	1,011,295	116,995	4,357	1,132,647		1,132,647	876	1,133,523		10
10a	Therapy		211	355,658	355,869		355,869		355,869		10a
11	Activities	31,622	3,065	2,268	36,955		36,955		36,955		11
12	Social Services	26,511	28	2,124	28,663		28,663		28,663		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,069,428</b>	<b>120,299</b>	<b>370,407</b>	<b>1,560,134</b>		<b>1,560,134</b>	<b>876</b>	<b>1,561,010</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	58,222			58,222		58,222	22,399	80,621		17
18	Directors Fees										18
19	Professional Services			244,154	244,154		244,154	(225,510)	18,644		19
20	Dues, Fees, Subscriptions & Promotions			14,043	14,043		14,043	(2,490)	11,553		20
21	Clerical & General Office Expenses	27,027	5,841	29,027	61,895		61,895	42,738	104,633		21
22	Employee Benefits & Payroll Taxes			224,241	224,241		224,241	10,411	234,652		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,220	4,220		4,220	4,471	8,691		24
25	Other Admin. Staff Transportation							308	308		25
26	Insurance-Prop.Liab.Malpractice			36,626	36,626		36,626	42	36,668		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>85,249</b>	<b>5,841</b>	<b>552,311</b>	<b>643,401</b>		<b>643,401</b>	<b>(147,631)</b>	<b>495,770</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,476,596</b>	<b>322,765</b>	<b>1,037,362</b>	<b>2,836,723</b>		<b>2,836,723</b>	<b>(154,072)</b>	<b>2,682,651</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: 1/1/08 Ending: 12/31/08

## 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			38,398	38,398	38,398	(594)	37,804			30
31	Amortization of Pre-Op. & Org.			494	494	494		494			31
32	Interest			107,876	107,876	107,876	(3,100)	104,776			32
33	Real Estate Taxes			53,879	53,879	53,879		53,879			33
34	Rent-Facility & Grounds						8,503	8,503			34
35	Rent-Equipment & Vehicles			87	87	87	3,878	3,965			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			200,734	200,734	200,734	8,687	209,421			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			41,724	41,724	41,724		41,724			42
43	Other (specify):* LAB			4,984	4,984	4,984		4,984			43
44	<b>TOTAL Special Cost Centers</b>			46,708	46,708	46,708		46,708			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,476,596	322,765	1,284,804	3,084,165	3,084,165	(145,385)	2,938,780			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: **1/1/08**

Ending: **12/31/08**

**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	(7,458)	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	(3,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	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	(1,177)	21		18
19	Entertainment				19
20	Contributions	(1,525)	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	(2,554)	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 ATTACHED	(1,247)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (17,288)		\$	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)	(128,097)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (128,097)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (145,385)		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		2,313	10.2	42
43	Prescription Drugs	X		71,809	10.2	43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 74,122		47

BHF USE ONLY						
48		49		50		51
						52

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	TRAVEL CHGD TO RESIDENTS	\$ (653)	24 1
2	DEPRECIATION - CAP COST AUDIT ADJS pg 12	(594)	30 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>	(1,247)	49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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	(7,685)	0	0	0	0	0	0	0	0	0	0	(7,685)	2
3	Housekeeping	0	0	160	0	0	0	0	0	0	0	0	160	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	208	0	0	0	0	0	0	0	0	0	208	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,685)</b>	<b>208</b>	<b>160</b>	<b>0</b>	<b>(7,317)</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	876	0	0	0	0	0	0	0	0	0	876	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>876</b>	<b>0</b>	<b>876</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	22,399	0	0	0	0	0	0	0	0	0	22,399	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(225,510)	0	0	0	0	0	0	0	0	0	(225,510)	19
20	Fees, Subscriptions & Promotions	(2,554)	64	0	0	0	0	0	0	0	0	0	(2,490)	20
21	Clerical & General Office Expenses	(2,702)	45,440	0	0	0	0	0	0	0	0	0	42,738	21
22	Employee Benefits & Payroll Taxes	0	10,411	0	0	0	0	0	0	0	0	0	10,411	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(653)	5,124	0	0	0	0	0	0	0	0	0	4,471	24
25	Other Admin. Staff Transportation	0	308	0	0	0	0	0	0	0	0	0	308	25
26	Insurance-Prop.Liab.Malpractice	0	42	0	0	0	0	0	0	0	0	0	42	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(5,909)</b>	<b>(141,722)</b>	<b>0</b>	<b>(147,631)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(13,594)</b>	<b>(140,638)</b>	<b>160</b>	<b>0</b>	<b>(154,072)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning:

1/1/08

Ending:

12/31/08

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	(594)	0	0	0	0	0	0	0	0	0	0	(594)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,100)	0	0	0	0	0	0	0	0	0	0	(3,100)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,503	0	0	0	0	0	0	0	0	0	8,503	34
35	Rent-Equipment & Vehicles	0	3,878	0	0	0	0	0	0	0	0	0	3,878	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,694)</b>	<b>12,381</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>8,687</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>(17,288)</b>	<b>(128,257)</b>	<b>160</b>	<b>0</b>	<b>(145,385)</b>	<b>45</b>							

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

# 0017590

Report Period Beginning:

1/1/08

Ending:

12/31/08

**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
<u>JAMES J. GIARDINA</u>	<u>100</u>	<u>MONMOUTH NURSING HOME</u>	<u>MASCOUTAH</u>	<u>COMMUNITY</u>	<u>BALLWIN, MO</u>	<u>HOME OFFICE</u>
		<u>MAR-KA NURSING HOME</u>	<u>MASCOUTAH</u>	<u>CARE CTRS, INC.</u>		
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>W/C INS</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>LIAB INS</u>

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)	
<u>1</u>	<u>V</u>	<u>19</u>	<u>HOME OFFICE/MGMT FEES</u>	<u>\$ 228,000</u>	<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>\$ (228,000)</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>34</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>8,503</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>35</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>3,878</u>	<u>3</u>
<u>4</u>	<u>V</u>	<u>17</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>22,399</u>	<u>4</u>
<u>5</u>	<u>V</u>	<u>21</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>45,440</u>	<u>5</u>
<u>6</u>	<u>V</u>	<u>10</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>876</u>	<u>6</u>
<u>7</u>	<u>V</u>	<u>22</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>10,411</u>	<u>7</u>
<u>8</u>	<u>V</u>	<u>19</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>2,490</u>	<u>8</u>
<u>9</u>	<u>V</u>	<u>24</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>5,124</u>	<u>9</u>
<u>10</u>	<u>V</u>	<u>25</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>308</u>	<u>10</u>
<u>11</u>	<u>V</u>	<u>6</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>208</u>	<u>11</u>
<u>12</u>	<u>V</u>	<u>20</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>64</u>	<u>12</u>
<u>13</u>	<u>V</u>	<u>26</u>	<u>HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>42</u>	<u>13</u>
<u>14</u>	<u>Total</u>		<u>\$ 228,000</u>			<u>\$ 99,743</u>	<u>\$ * (128,257)</u>	<u>14</u>

\* 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: **1/1/08**

Ending: **12/31/08**

**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	3 HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC.	100.00%	\$ 160	\$	160	15
16	V	22 WORKERS COMP INSURANCE	62,316	RISA	25.00%	62,316			16
17	V	26 LIABILITY INSURANCE	30,400	RISA	25.00%	30,400			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 92,716			\$ 92,876	\$ *	160	39

\* 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: 1/1/08 Ending: 12/31/08

## 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	\$ 16,397	17.7	1
2	BETTY HUGHES	SECRETARY			NONE	1	2.00	SALARY	1,372	17.7	2
3	LORRAINE BOYET	SECRETARY			NONE	2	4.00	SALARY	1,732	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,501		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: 1/1/08

Ending: 12/31/08

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	WEST COUNTY CARE CENTER			\$	\$	5,576,345	\$ 282,290	1
2		ST GENEVIEVE CARE CTR					2,367,632	83,909	2
3		CCC OF LEMAY					2,479,484	96,051	3
4		SALEM CARE CENTER					1,746,988	63,666	4
5		MONMOUTH NH					2,126,548	81,939	5
6		MAR-KA NH					2,712,435	120,923	6
7		CCC OF SENECA					2,734,042	100,226	7
8		MT VERNON PLACE CARE					2,601,692	98,578	8
9		COUNTRY VIEW NH					2,220,110	88,721	9
10		MERAMEC NH					2,805,995	108,740	10
11		SEVILLE CARE CENTER					3,145,601	112,149	11
12		SALEM RES CARE					556,627	19,492	12
13		CARL JUNCTION RES CARE					612,517	21,449	13
14		MT VERNON RES CARE					462,316	16,190	14
15		SENECA HOME PLACE					447,852	15,684	15
16		HUDSON HOUSE					517,592	18,125	16
17		MAPLE GROVE LODGE					3,049,347	117,264	17
18		CCC OF AURORA					4,817,184	170,686	18
19		BARRY COMMUNITY CARE					2,824,348	99,903	19
20		LICKING RESIDENTIAL CTR					445,895	15,614	20
21		CCC OF GAINESVILLE					2,514,144	94,279	21
22		AL OF SILVER CREEK					654,275	22,912	22
23		CCC OF LICKING					2,483,065	97,672	23
24		COMMUNITY IN HOME					913,173	32,238	24
25	TOTALS				\$	\$		\$ 1,978,700	25

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER** # **0017590** Report Period Beginning: **1/1/08** Ending: **12/31/08**

**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	\$ 1,370,102	9/6/08	6.0000	\$ 93,884						
2	GE COMMERCIAL FINANCE	X		FIRE ALARM SYSTEM	\$573.51	1/10/07	23,455	13,279	5/2/07	12.7000	1,504						
3											3						
4											4						
5											5						
<b>Working Capital</b>																	
6	FIRST NAT'L BANK OF BARRY	X		WORKING CAP-LOC				98,000		VAR	12,473						
7	MISC INTEREST	X									15						
8											8						
9	<b>TOTAL Facility Related</b>				\$12,206.02		\$ 1,523,455	\$ 1,481,381			\$ 107,876						
<b>B. Non-Facility Related*</b>																	
10											10						
11											11						
12											12						
13											13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,523,455	\$ 1,481,381			\$ 107,876						

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: **1/1/08**

Ending: **12/31/08**

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2007 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>53,839</b>	<b>2</b>																													
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>19,039</b>	<b>3</b>																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>34,840</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>53,879</b>	<b>7</b>																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td><b>43,142</b></td><td><b>8</b></td></tr> <tr><td>2004</td><td><b>46,638</b></td><td><b>9</b></td></tr> <tr><td>2005</td><td><b>48,796</b></td><td><b>10</b></td></tr> <tr><td>2006</td><td><b>51,977</b></td><td><b>11</b></td></tr> <tr><td>2007</td><td><b>53,839</b></td><td><b>12</b></td></tr> </table>	2003	<b>43,142</b>	<b>8</b>	2004	<b>46,638</b>	<b>9</b>	2005	<b>48,796</b>	<b>10</b>	2006	<b>51,977</b>	<b>11</b>	2007	<b>53,839</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6 \$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td><b>16</b></td></tr> </table>	<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007 \$	<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>
2003	<b>43,142</b>	<b>8</b>																														
2004	<b>46,638</b>	<b>9</b>																														
2005	<b>48,796</b>	<b>10</b>																														
2006	<b>51,977</b>	<b>11</b>																														
2007	<b>53,839</b>	<b>12</b>																														
<b>FOR BHF USE ONLY</b>																																
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007 \$	<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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

	(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>53,839.00</u>	\$ <u>53,839.00</u>
2.	<u>                    </u>	<u>PT S SIDE NE</u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>53,839.00</u>	\$ <u>53,839.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

1/1/08 Ending:

12/31/08

**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).

---

---

---

---

---

---

---

---

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:

1/1/08

Ending:

12/31/08

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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		2,039	10
11		ROOF		1995	27,030	1,802	15	1,802		24,778	11
12		BLACKTOP DRIVE		1998	6,300	420	15	420		4,338	12
13		NEW CEILING (Lowered to 11,747 from 12,227 CAP DESK AUDIT)		2001	11,747	1,223	10	1,175	(48)	8,517	13
14		CARRIER ROOF TOP UNIT		2001	10,980	1,098	10	1,098		8,327	14
15		AIR HANDLER A/C FOR KITCHEN (REMOVED CAP DESK AUDIT)		2001		114			(114)		15
16		LIGHT FIXTURES, PAINT		2001	1,441	144	10	144		1,032	16
17		76 RESIDENT ROOM WALL BRACKET LIGHTS		2001	6,656	666	10	666		4,770	17
18											18
19		AMER STANDARD 15T RFTOP A/C		2004	11,475	1,148	10	1,148		5,355	19
20											20
21		85-GALLON WATER HEATER		2005	5,016	502	10	502		1,757	21
22		CARPET-FOYER, OFFICES		2005	5,373	1,075	5	1,075		3,492	22
23		TILE FLOORING DIN RM, LV RM		2005	5,598	560	10	560		1,819	23
24		PAINTING		2005	15,490	1,549	10	1,549		4,647	24
25		WAINSCOTING		2005	4,187	419	10	419		1,256	25
26		CEILING LIGHT FIXTURES (REMOVED CAP DESK AUDIT 2008)		2005		112			(112)		26
27		WALLPAPER		2005	8,958	896	10	896		2,687	27
28		OUTDOOR LIGHTS (REMOVED CAP DESK AUDIT 2008)		2005		119			(119)		28
29		LANDSCAPING		2005	7,080	708	10	708		2,242	29
30		BRICK SIGN		2005	4,895	489	10	489		1,509	30
31		CONCRETE WORK		2005	1,931	129	15	129		397	31
32		LANDSCAPING (REMOVED CAP DESK AUDIT 2008)		2006		102			(102)		32
33		CONCRETE WORK		2006	4,625	308	15	308		642	33
34		RE-ROOF FRONT ENTRANCE		2006	1,592	159	10	159		478	34
35		HALL LIGHTS (REMOVED CAP DESK AUDIT 2008)		2006		99			(99)		35
36		NEW WINDOWS		2006	2,172	217	10	217		634	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:

1/1/08

Ending:

12/31/08

**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	\$ 225	10	\$ 225	\$	\$ 547	37
38	FLOORING DINING ROOM	2006	3,677	368	10	368		1,103	38
39	SS WALLCOVERING BEHIND STOVE	2006	1,408	282	5	282		634	39
40	FIREPROOFING & FIREWALLS	2006	1,900	380	5	380		792	40
41	FIRE ALARM SYSTEM	2007	23,455	2,346	10	2,346		4,691	41
42	ADDL SPRINKLER SYSTEM	2008	7,825	652	10	652		652	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)		\$ 992,068	\$ 18,406		\$ 17,812	\$ (594)	\$ 895,126	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: 1/1/08 Ending: 12/31/08

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	\$ 272,318	\$ 18,568	\$ 18,568	\$	VAR	\$ 189,468	71
72	Current Year Purchases	8,397	226	226		VAR	226	72
73	Fully Depreciated Assets	125,471					124,813	73
74								74
75	TOTALS	\$ 406,186	\$ 18,794	\$ 18,794	\$		\$ 314,507	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	\$ 1,198	\$ 1,198	\$	4	\$ 19,174	76
77										77
78										78
79										79
80	TOTALS			\$ 19,175	\$ 1,198	\$ 1,198	\$		\$ 19,174	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)	\$ 1,438,168	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,804	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (594)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,228,807	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 87 Description: PROPANE TANK \$50; TOOLS \$37

(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: 1/1/08 Ending: 12/31/08

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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.3	hrs	\$	1,753	\$ 115,917	\$ 184	1,753	\$ 116,101	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		408	31,021		408	31,021	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		3,092	208,720	27	3,092	208,747	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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	5,253	\$ 355,658	\$ 211	5,253	\$ 355,869	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: **1/1/08**

Ending:

**12/31/08****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/08**

(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	\$ 122,921	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	844,918		3
4	Supply Inventory (priced at <u>COST</u> )	2,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,156		6
7	Other Prepaid Expenses	22,855		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>	\$ 1,696,036	\$	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	998,007		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	425,361		16
17	Accumulated Depreciation (book methods)	(1,226,304)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	53,884		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(51,808)		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>	\$ 220,879	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,916,915	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,144,678	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	98,000		29
30	Accrued Salaries Payable	89,789		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,383		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,840		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/FROM RELATED PARTIES</u>	(13,124)		36
37	<u>PT FUNDS/UNEARNED INCOME</u>	134,746		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,499,312	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	13,279		39
40	Mortgage Payable	1,370,102		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>	\$ 1,383,381	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,882,693	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (965,778)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,916,915	\$	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>(1,540,688)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>(1)</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>(1,540,689)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>574,911</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>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>574,911</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>(965,778)</b>	<b>24</b> *

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER# 0017590Report Period Beginning: 1/1/08Ending: 12/31/08**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	\$ 14,189,725	1
2	Discounts and Allowances for all Levels	(11,444,501)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,745,224	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	738,696	6
7	Oxygen	163,945	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 902,641	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	7,458	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>	\$ 7,458	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,100	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,100	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Tvl Chgd Residents</u>	653	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 653	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,659,076	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	633,188	31
32	Health Care	1,560,134	32
33	General Administration	643,401	33
<b>B. Capital Expense</b>			
34	Ownership	200,734	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,984	35
36	Provider Participation Fee	41,724	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,084,165	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	574,911	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 574,911	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: **1/1/08**

Ending:

**12/31/08**

**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	1,756	2,080	\$ 52,782	\$ 25.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,042	5,378	117,863	21.92	3
4	Licensed Practical Nurses	15,378	16,430	251,174	15.29	4
5	CNAs & Orderlies	57,829	61,036	579,424	9.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	1,997	19,209	9.62	9
10	Activity Assistants	1,088	1,172	12,413	10.59	10
11	Social Service Workers	1,978	2,154	26,511	12.31	11
12	Dietician					12
13	Food Service Supervisor	2,418	2,561	26,350	10.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,530	5,714	52,678	9.22	15
16	Dishwashers	9,818	10,490	84,680	8.07	16
17	Maintenance Workers	2,090	2,194	22,500	10.26	17
18	Housekeepers	11,638	12,162	104,164	8.56	18
19	Laundry	3,372	3,568	31,547	8.84	19
20	Administrator	1,724	2,080	58,222	27.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,987	2,188	27,027	12.35	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	992	1,003	10,052	10.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>124,556</b>	<b>132,207</b>	<b>\$ 1,476,596 *</b>	<b>\$ 11.17</b>	<b>34</b>

\* 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	107	\$ 4,026	1.3	35
36	Medical Director	96	6,000	9.3	36
37	Medical Records Consultant	40	2,130	10.3	37
38	Nurse Consultant		226	10.3	38
39	Pharmacist Consultant	80	2,001	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	27	2,268	11.3	44
45	Social Service Consultant	24	2,124	12.3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>374</b>	<b>\$ 18,775</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>		<b>\$</b>	<b>53</b>





**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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 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. \$ 6,077 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. \$ 41,724  
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. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation. Schedule attached
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 70%
- 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. \$ N/A**
- (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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.