

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

0017590 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	11,516	5,716	1,741	18,973	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,516	5,716	1,741	18,973	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.40%

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 6/1/2011 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 1,592

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

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
	A. General Services										
1	Dietary	177,158	12,432	3,792	193,382		193,382		193,382		1
2	Food Purchase		118,145		118,145		118,145	(9,942)	108,203		2
3	Housekeeping	105,400	14,120		119,520		119,520	143	119,663		3
4	Laundry	41,854	15,981		57,835		57,835		57,835		4
5	Heat and Other Utilities			73,914	73,914		73,914		73,914		5
6	Maintenance	28,631	20,018	25,148	73,797		73,797	657	74,454		6
7	Other (specify):*										7
8	TOTAL General Services	353,043	180,696	102,854	636,593		636,593	(9,142)	627,451		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,036,386	123,802	6,097	1,166,285		1,166,285	31,040	1,197,325		10
10a	Therapy		201	237,672	237,873		237,873		237,873		10a
11	Activities	45,302	4,230	2,023	51,555		51,555		51,555		11
12	Social Services	22,223	46	2,023	24,292		24,292		24,292		12
13	CNA Training										13
14	Program Transportation							(100)	(100)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,103,911	128,279	253,815	1,486,005		1,486,005	30,940	1,516,945		16
	C. General Administration										
17	Administrative	62,902			62,902		62,902	10,400	73,302		17
18	Directors Fees			2,400	2,400		2,400		2,400		18
19	Professional Services			244,016	244,016	(123,802)	120,214	(226,500)	(106,286)		19
20	Dues, Fees, Subscriptions & Promotions			14,338	14,338		14,338	(4,409)	9,929		20
21	Clerical & General Office Expenses	33,238	5,082	32,147	70,467		70,467	52,351	122,818		21
22	Employee Benefits & Payroll Taxes			213,098	213,098		213,098	9,869	222,967		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,892	7,892		7,892	2,848	10,740		24
25	Other Admin. Staff Transportation							392	392		25
26	Insurance-Prop.Liab.Malpractice			34,109	34,109		34,109	43	34,152		26
27	Other (specify):*										27
28	TOTAL General Administration	96,140	5,082	548,000	649,222	(123,802)	525,420	(155,006)	370,414		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,553,094	314,057	904,669	2,771,820	(123,802)	2,648,018	(133,208)	2,514,810		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,697	39,697		39,697	11,449	51,146			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,570	24,570		24,570	29,471	54,041			32
33	Real Estate Taxes			56,087	56,087		56,087		56,087			33
34	Rent-Facility & Grounds			273,600	273,600		273,600	(267,659)	5,941			34
35	Rent-Equipment & Vehicles							2,441	2,441			35
36	Other (specify):*											36
37	TOTAL Ownership			393,954	393,954		393,954	(224,298)	169,656			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			93,389	93,389	123,802	217,191		217,191			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,712	229,712		229,712		229,712			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			323,101	323,101	123,802	446,903		446,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,553,094	314,057	1,621,724	3,488,875		3,488,875	(357,506)	3,131,369			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,765)	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	(27,379)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(177)	2		12
13	Sales Tax				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	(1,127)	21		18
19	Entertainment				19
20	Contributions	(2,101)	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	(4,025)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(482)	20		28
29	Other-Attach Schedule	(3,011)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,067)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (48,067)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MISCELLANEOUS INCOME - REBATES	\$ (2,479)	21	1
2	RESIDENT TRANSPORTATION	(100)	14	2
3	DEPRECIATION - CAP COST AUDIT ADJS pg 12	(432)	30	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	Total		(3,011)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

0017590

Report Period Beginning:

1/1/13

Ending:

12/31/13

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,942)	0	0	0	0	0	0	0	0	0	0	(9,942)	2
3	Housekeeping	0	0	143	0	0	0	0	0	0	0	0	143	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	657	0	0	0	0	0	0	0	0	0	657	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,942)	657	143	0	(9,142)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	31,040	0	0	0	0	0	0	0	0	0	31,040	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	(100)	0	0	0	0	0	0	0	0	0	0	(100)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(100)	31,040	0	30,940	16								
	C. General Administration													
17	Administrative	0	10,400	0	0	0	0	0	0	0	0	0	10,400	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(226,500)	0	0	0	0	0	0	0	0	0	(226,500)	19
20	Fees, Subscriptions & Promotions	(4,507)	98	0	0	0	0	0	0	0	0	0	(4,409)	20
21	Clerical & General Office Expenses	(5,707)	58,058	0	0	0	0	0	0	0	0	0	52,351	21
22	Employee Benefits & Payroll Taxes	0	9,869	0	0	0	0	0	0	0	0	0	9,869	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,848	0	0	0	0	0	0	0	0	0	2,848	24
25	Other Admin. Staff Transportation	0	392	0	0	0	0	0	0	0	0	0	392	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	TOTAL General Administration	(10,214)	(144,792)	0	(155,006)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,256)	(113,095)	143	0	(133,208)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER# 0017590

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(432)	0	11,881	0	0	0	0	0	0	0	0	11,449	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27,379)	0	56,850	0	0	0	0	0	0	0	0	29,471	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,941	(273,600)	0	0	0	0	0	0	0	0	(267,659)	34
35	Rent-Equipment & Vehicles	0	2,441	0	0	0	0	0	0	0	0	0	2,441	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,811)	8,382	(204,869)	0	(224,298)	37							
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(48,067)	(104,713)	(204,726)	0	0	0	0	0	0	0	0	(357,506)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J. GIARDINA	100	MONMOUTH NURSING HOME	MASCOUTAH	COMMUNITY CARE CENTERS	BALLWIN, MO	HOME OFFICE
		MAR-KA NURSING HOME	MASCOUTAH	RISA	JEFFERSON CITY, MO	LIAB INS
				BARRY HOLDING COMPANY LLC	BALLWIN, MO	FACILITY LEASE

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
	V	19 HOME OFFICE/MGMT FEES	\$ 228,000	COMMUNITY CARE CENTERS, INC.	100.00%	\$	\$ (228,000)	1
	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	5,941	5,941	2
	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,441	2,441	3
	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	10,400	10,400	4
	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	58,058	58,058	5
	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	31,040	31,040	6
	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	9,869	9,869	7
	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,500	1,500	8
	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,848	2,848	9
	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	392	392	10
	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	657	657	11
	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	98	98	12
	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	43	43	13
14	Total		\$ 228,000			\$ 123,287	\$ * (104,713)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC.	100.00%	\$ 143	\$ 143
16	V	26 LIABILITY INSURANCE	34,200	RISA	25.00%	34,200	
17	V	34 BUILDING RENT	273,600	BARRY HOLDING COMPANY LLC	100.00%		(273,600)
18	V	30 DEPRECIATION		BARRY HOLDING COMPANY LLC	100.00%	11,881	11,881
19	V	32 INTEREST EXPENSE		BARRY HOLDING COMPANY LLC	100.00%	56,850	56,850
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		\$ 307,800			\$ 103,074	\$ * (204,726)

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	\$ 8,316	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	6.00	SALARY	1,432	17.7	2
3	JESSICA CRANE	SECRETARY			NONE	1	4.00	SALARY	652	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,400		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:

1/1/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization COMMUNITY CARE CENTERS, INC
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	WEST COUNTY CARE CENTER				\$	\$	5,784,828	\$	1
2	ST GENEVIEVE CARE CTR						2,721,730		2
3	CCC OF LEMAY						2,758,746		3
4	SALEM CARE CENTER						2,018,561		4
5	MONMOUTH NH						2,904,949		5
6	MAR-KA NH						3,030,494		6
7	CCC OF SENECA						3,302,483		7
8	MT VERNON PLACE CARE						3,283,148		8
9	COUNTRY VIEW NH						2,549,564		9
10	MERAMEC NH						2,855,753		10
11	SEVILLE CARE CENTER						3,501,582		11
12	SALEM RES CARE						618,784		12
13	CARL JUNCTION RES CARE						727,464		13
14	MT VERNON RES CARE						492,776		14
15	SENECA HOME PLACE						470,064		15
16	HUDSON HOUSE						617,735		16
17	MAPLE GROVE LODGE						3,409,999		17
18	CCC OF AURORA						4,488,628		18
19	BARRY COMMUNITY CARE						3,166,164		19
20	LICKING RESIDENTIAL CTR						402,502		20
21	CCC OF GAINESVILLE						3,519,536		21
22	AL OF SILVER CREEK						788,475		22
23	MARK TWAIN MANOR						6,342,220		23
24	CCC OF LICKING						2,775,510		24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER

0017590

Report Period Beginning:

1/1/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization COMMUNITY CARE CENTERS, INC.
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

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

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	COMMUNITY IN HOME				\$	\$	1,052,552	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
A. Directly Facility Related																	
Long-Term																	
1	CFS CORP FLEET SERVICES		X	LEASE/PURCH BUS	\$975.17	4/8/11	\$ 51,580	\$ 30,946	4/8/17	11.4780	\$ 4,037						
2																	
3																	
4																	
5																	
Working Capital																	
6	FIRST NAT'L BANK OF BARRY		X	WORKING CAP-LOC		VAR	VAR	427,087		VAR	20,533						
7																	
8																	
9	TOTAL Facility Related				\$975.17		\$ 51,580	\$ 458,033			\$ 24,570						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 51,580	\$ 458,033			\$ 24,570						

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

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

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

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 2012 report.		\$	34,840		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	56,087		2
3. Under or (over) accrual (line 2 minus line 1).		\$	21,247		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	34,840		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	56,087		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>47,270</u>	8		
	2009	<u>46,623</u>	9		
	2010	<u>47,948</u>	10		
	2011	<u>49,943</u>	11		
	2012	<u>56,087</u>	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2012 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 2012 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 2012.

	(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>56,087.00</u>	\$ <u>56,087.00</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>
		TOTALS	\$ <u><u>56,087.00</u></u>	\$ <u><u>56,087.00</u></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 NO

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

1/1/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,930 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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	TOTALS	5.04 ACRES		\$ 20,739	3

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

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		Feb-75	1975	\$ 805,055	\$	30	\$	\$	\$ 805,055	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		PATIO		1976	936		20			936	9
10		DRIVE		1987	3,002	95	31	95		1,249	10
11		ROOF		1995	27,030		15			27,030	11
12		BLACKTOP DRIVE		1998	6,300	282	15	282		6,300	12
13		NEW CEILING (Lowered to 11,747 from 12,227 CAP DESK AUDIT)		2001	11,747		10			11,747	13
14		CARRIER ROOF TOP UNIT		2001	10,980		10			10,980	14
15		AIR HANDLER A/C FOR KITCHEN (REMOVED CAP DESK AUDIT)		2001							15
16		LIGHT FIXTURES, PAINT		2001	1,441		10			1,441	16
17		76 RESIDENT ROOM WALL BRACKET LIGHTS		2001	6,656		10			6,656	17
18		FIRE ALARM SYSTEM (REMOVED IN 2013)		2004		7		6	(1)		18
19		AMER STANDARD 15T RFTOP A/C		2004	11,475	1,148	10	1,148		11,093	19
20											20
21		85-GALLON WATER HEATER		2005	5,016	502	10	502		4,264	21
22		CARPET-FOYER, OFFICES		2005	5,373		5			5,373	22
23		TILE FLOORING DIN RM, LV RM		2005	5,598	560	10	560		4,618	23
24		PAINTING		2005	15,490	1,549	10	1,549		12,392	24
25		WAINSCOTING		2005	4,187	419	10	419		3,349	25
26		CEILING LIGHT FIXTURES (REMOVED CAP DESK AUDIT 2008)		2005		112			(112)		26
27		WALLPAPER		2005	8,958	896	10	896		7,166	27
28		OUTDOOR LIGHTS (REMOVED CAP DESK AUDIT 2008)		2005		119			(119)		28
29		LANDSCAPING		2005	7,080	708	10	708		5,782	29
30		BRICK SIGN		2005	4,895	489	10	489		3,957	30
31		CONCRETE WORK		2005	1,931	129	15	129		1,041	31
32		LANDSCAPING (REMOVED CAP DESK AUDIT 2008)		2006		102			(102)		32
33		CONCRETE WORK		2006	4,625	308	15	308		2,184	33
34		RE-ROOF FRONT ENTRANCE		2006	1,592	159	10	159		1,274	34
35		HALL LIGHTS (REMOVED CAP DESK AUDIT 2008)		2006		99			(99)		35
36		NEW WINDOWS		2006	2,172	217	10	217		1,720	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:

1/1/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NEW WINDOWS	2006	\$ 2,264	\$ 226	10	\$ 226	\$	\$ 1,679	37
38	FLOORING DINING ROOM	2006	3,677	368	10	368		2,941	38
39	SS WALLCOVERING BEHIND STOVE	2006	1,408		5			1,408	39
40	FIREPROOFING & FIREWALLS	2006	1,900		5			1,900	40
41	FIRE ALARM SYSTEM	2007	23,455	2,346	10	2,346		16,419	41
42	ADDL SPRINKLER SYSTEM	2008	7,825	783	10	783		4,565	42
43	FLOORING	2010	1,325	132	10	132		519	43
44	8 REPLACEMENT WINDOWS	2010	1,265	126	10	126		401	44
45	5 TON 13-SEER A/C SYSTEM	2011	3,744	1,248	LEASE LIFE	1,248		3,744	45
46	ASPHALT SEALING	2011	3,003	1,060	LEASE LIFE	1,060		2,561	46
47	CONCRETE SIDEWALKS	2011	2,774	1,074	LEASE LIFE	1,074		2,326	47
48	ELECTRIC COMMERCIAL WATER HEATER 85 GAL	2011	4,817	1,927	LEASE LIFE	1,927		4,014	48
49	VINYL SIDING, GUTTER EDGE OF ROOF	2012	13,346	5,523	LEASE LIFE	5,523		11,045	49
50	MIXING VALVE FOR WATER HEATER	2012	1,470	608	LEASE LIFE	608		1,217	50
51	BACKFLOW PREVENTION DEVICE	2012	7,400	4,674	LEASE LIFE	4,674		5,453	51
52	ALARM SYSTEM CPU	2013	1,409	704	8	704		704	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)		\$ 1,032,621	\$ 28,699		\$ 28,266	\$ (433)	\$ 996,503	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 300,781	\$ 9,767	\$ 9,767	\$	VAR	\$ 346,538	71
72	Current Year Purchases	1,635	218	218		VAR	218	72
73	Fully Depreciated Assets	121,534					121,534	73
74								74
75	TOTALS	\$ 423,950	\$ 9,985	\$ 9,985	\$		\$ 468,290	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	2003 CHEVY SAVANA	2003	4/18/2004	\$ 19,175	\$	\$	\$		\$ 19,175	76
77	2011 CHAMP 15-PAS BUS	2011	4/8/2011	51,580	12,895	12,895			35,461	77
78										78
79										79
80	TOTALS			\$ 70,755	\$ 12,895	\$ 12,895	\$		\$ 54,636	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)	\$ 1,548,065	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,579	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,146	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (433)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,519,429	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	TOTAL				\$			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ **0** Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/13 Ending: 12/31/13
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)		
TOTAL TRAINED		

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

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

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

	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	\$		\$ 104,528	\$		\$ 104,528	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs			18,392			18,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs			114,752			114,752	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescripts				83,650		83,650	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB & XRAY	39.3					9,739		9,739	12
13	Other (specify):									13
14	TOTAL			\$		\$ 237,672	\$ 93,389		\$ 331,061	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: **1/1/13**

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/13** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 35,699	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	804,805		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,747		6
7	Other Prepaid Expenses	(5,528)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): NOTE REC-INTERCO	1,627,428		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,465,151	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	37,963		15
16	Equipment, at Historical Cost	494,705		16
17	Accumulated Depreciation (book methods)	(453,672)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	56,105		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(56,105)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	4,800		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 83,796	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,548,947	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 256,016	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	427,087		29
30	Accrued Salaries Payable	92,152		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,198		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
Other Current Liabilities(specify):				
36	DUE T/F CCC, INC; ACC MGMT FEES	1,682,000		36
37	PT FUNDS/UNEARNED INCOME	5,589		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,506,882	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	30,946		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 30,946	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,537,828	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,119	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,548,947	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 335,725	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 335,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(324,606)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (324,606)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,119	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,131,945	1
2	Discounts and Allowances for all Levels	(13,977,074)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,154,871	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	693,284	6
7	Oxygen	192,211	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 885,495	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	530	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,765	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,650	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,945	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	27,379	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,379	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC REBATES 2,479; RESIDENT TRAVEL 100	2,579	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,579	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,164,269	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	636,593	31
32	Health Care	1,486,005	32
33	General Administration	649,222	33
B. Capital Expense			
34	Ownership	393,954	34
C. Ancillary Expense			
35	Special Cost Centers	93,389	35
36	Provider Participation Fee	229,712	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,488,875	40
41	Income before Income Taxes (line 30 minus line 40)**	(324,606)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (324,606)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,258,925	44
45	Private Pay - Net Inpatient Revenue	916,076	45
46	Medicare - Net Inpatient Revenue	102,605	46
47	Other-(specify) HOSPICE	1,250	47
48	Other-(specify) BAD DEBTS/PY CONTR ADJS	(123,985)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,154,871	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

1/1/13

Ending:

12/31/13

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	1,936	2,080	\$ 52,751	\$ 25.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,856	7,248	165,661	22.86	3
4	Licensed Practical Nurses	12,451	13,204	230,133	17.43	4
5	CNAs & Orderlies	49,476	52,525	565,427	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,737	2,025	27,394	13.53	9
10	Activity Assistants	1,556	1,964	17,907	9.12	10
11	Social Service Workers	1,582	1,694	22,223	13.12	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,082	24,993	12.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,184	4,400	46,724	10.62	15
16	Dishwashers	11,420	11,848	105,441	8.90	16
17	Maintenance Workers	1,653	1,713	28,631	16.71	17
18	Housekeepers	10,539	11,044	105,400	9.54	18
19	Laundry	3,873	4,145	41,854	10.10	19
20	Administrator	1,784	2,080	62,902	30.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,917	2,135	33,238	15.57	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	1,887	2,031	22,415	11.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,821	122,218	\$ 1,553,094 *	\$ 12.71	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	101	\$ 3,792	1.3	35
36	Medical Director	96	6,000	9.3	36
37	Medical Records Consultant	32	1,880	10.3	37
38	Nurse Consultant		215	10.3	38
39	Pharmacist Consultant	96	4,002	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	23	1,339	11.3	44
45	Social Service Consultant	23	1,339	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	371	\$ 18,567		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER**# **0017590**Report Period Beginning: **1/1/13**Ending: **12/31/13****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
- (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? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,520 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. \$ 229,712
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.
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? 78%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (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.