

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0017590

Facility Name: BARRY COMMUNITY CARE CTR

Address: 1313 PRATT ST BARRY 62312
Number City Zip Code

County: PIKE

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

HFS ID Number:

Date of Initial License for Current Owners: 1975

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☒	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	JAMES J. GIARDINA	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	DARRYL E. BUEKER, CPA PARTNER	
	(Firm Name & Address)	BKD, LLP P. O. BOX 1190, SPRINGFIELD, MO 65801-1190	
	(Telephone)	(417) 865-8701	Fax # (417) 865-0682
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		
	Phone # (217) 782-1630		

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

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	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	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	<u>76</u>	TOTALS	<u>76</u>	<u>27,816</u>	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	<u>11,933</u>	<u>6,519</u>	<u>1,892</u>	<u>20,344</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,933</u>	<u>6,519</u>	<u>1,892</u>	<u>20,344</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.14%

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?

YESG. 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 6/1/2011NO ☐

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 1,697Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

* 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	192,664	15,270	3,129	211,063		211,063		211,063			1
2	Food Purchase		123,416		123,416		123,416	(12,268)	111,148			2
3	Housekeeping	117,715	18,287		136,002		136,002	148	136,150			3
4	Laundry	39,169	14,943		54,112		54,112		54,112			4
5	Heat and Other Utilities			83,011	83,011		83,011		83,011			5
6	Maintenance	35,155	18,581	28,118	81,854		81,854	149	82,003			6
7	Other (specify):*											7
8	TOTAL General Services	384,703	190,497	114,258	689,458		689,458	(11,971)	677,487			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,067,622	112,016	6,697	1,186,335		1,186,335	13,164	1,199,499			10
10a	Therapy		66	235,553	235,619		235,619		235,619			10a
11	Activities	43,304	3,806	2,180	49,290		49,290		49,290			11
12	Social Services	28,454	469	2,180	31,103		31,103		31,103			12
13	CNA Training			1,472	1,472		1,472		1,472			13
14	Program Transportation							(66)	(66)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,139,380	116,357	254,082	1,509,819		1,509,819	13,098	1,522,917			16
	C. General Administration											
17	Administrative	63,743			63,743		63,743	10,506	74,249			17
18	Directors Fees			2,400	2,400		2,400		2,400			18
19	Professional Services			248,300	248,300		248,300	(226,069)	22,231			19
20	Dues, Fees, Subscriptions & Promotions			11,724	11,724		11,724	(4,907)	6,817			20
21	Clerical & General Office Expenses	32,877	4,526	30,490	67,893		67,893	37,446	105,339			21
22	Employee Benefits & Payroll Taxes			230,378	230,378		230,378	10,344	240,722			22
23	Inservice Training & Education			833	833		833		833			23
24	Travel and Seminar			9,474	9,474		9,474	3,788	13,262			24
25	Other Admin. Staff Transportation							270	270			25
26	Insurance-Prop.Liab.Malpractice			47,026	47,026		47,026	40	47,066			26
27	Other (specify):*											27
28	TOTAL General Administration	96,620	4,526	580,625	681,771		681,771	(168,582)	513,189			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,620,703	311,380	948,965	2,881,048		2,881,048	(167,455)	2,713,593			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			37,253	37,253		37,253	11,580	48,833			30
31	Amortization of Pre-Op. & Org.			4,297	4,297		4,297		4,297			31
32	Interest			27,640	27,640		27,640	56,165	83,805			32
33	Real Estate Taxes			49,943	49,943		49,943		49,943			33
34	Rent-Facility & Grounds			273,600	273,600		273,600	(267,224)	6,376			34
35	Rent-Equipment & Vehicles							1,330	1,330			35
36	Other (specify):*											36
37	TOTAL Ownership			392,733	392,733		392,733	(198,149)	194,584			37
	Ancillary Expense											
	E. Special Cost Centers											
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			166,396	166,396		166,396		166,396			42
43	Other (specify):* Lab			8,454	8,454		8,454		8,454			43
44	TOTAL Special Cost Centers			174,850	174,850		174,850		174,850			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,620,703	311,380	1,516,548	3,448,631		3,448,631	(365,604)	3,083,027			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	(12,069)	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	(4,091)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	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	(1,489)	21		18
19	Entertainment				19
20	Contributions	(1,962)	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	(4,509)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(478)	20		28
29	Other-Attach Schedule	(13,748)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,545)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(327,059)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (327,059)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (365,604)		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			1,533	10.2	42
43	Prescription Drugs			66,932	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 68,465		47

STATE OF ILLINOIS
BARRY COMMUNITY CARE CTR

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	MISCELLANEOUS INCOME - REBATES	\$ (13,250)	21	1
2	DEPRECIATION - CAP COST AUDIT ADJS pg 12	(432)	30	2
3	RESIDENT TRANSPORTATION	(66)	14	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	(13,748)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,268)	0	0	0	0	0	0	0	0	0	0	(12,268)	2
3	Housekeeping	0	0	148	0	0	0	0	0	0	0	0	148	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	149	0	0	0	0	0	0	0	0	0	149	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,268)	149	148	0	0	0	0	0	0	0	0	(11,971)	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	13,164	0	0	0	0	0	0	0	0	0	13,164	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	(66)	0	0	0	0	0	0	0	0	0	0	(66)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(66)	13,164	0	0	0	0	0	0	0	0	0	13,098	16
	C. General Administration													
17	Administrative	0	10,506	0	0	0	0	0	0	0	0	0	10,506	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(226,069)	0	0	0	0	0	0	0	0	0	(226,069)	19
20	Fees, Subscriptions & Promotions	(4,987)	80	0	0	0	0	0	0	0	0	0	(4,907)	20
21	Clerical & General Office Expenses	(16,701)	54,147	0	0	0	0	0	0	0	0	0	37,446	21
22	Employee Benefits & Payroll Taxes	0	10,344	0	0	0	0	0	0	0	0	0	10,344	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,788	0	0	0	0	0	0	0	0	0	3,788	24
25	Other Admin. Staff Transportation	0	270	0	0	0	0	0	0	0	0	0	270	25
26	Insurance-Prop.Liab.Malpractice	0	40	0	0	0	0	0	0	0	0	0	40	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,688)	(146,894)	0	0	0	0	0	0	0	0	0	(168,582)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,022)	(133,581)	148	0	0	0	0	0	0	0	0	(167,455)	29

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	(432)	0	12,012	0	0	0	0	0	0	0	0	11,580	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,091)	0	60,256	0	0	0	0	0	0	0	0	56,165	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,376	(273,600)	0	0	0	0	0	0	0	0	(267,224)	34
35	Rent-Equipment & Vehicles	0	1,330	0	0	0	0	0	0	0	0	0	1,330	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,523)	7,706	(201,332)	0	0	0	0	0	0	0	0	(198,149)	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)	(38,545)	(125,875)	(201,184)	0	0	0	0	0	0	0	0	(365,604)	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	BALLWIN, MO	HOME OFFICE
		MAR-KA NURSING HOME	MASCOUTAH	CARE CENTERS		
				RISA	JEFFERSON CITY, MO	LIAB INS
				BARRY HOLDING	BALLWIN, MO	FACILITY LEASE
				COMPANY LLC		

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)	
1	V	19	HOME OFFICE/MGMT FEES	\$ 228,000	COMMUNITY CARE CENTERS, INC.	100.00%	\$	(228,000)	1
2	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	6,376	6,376	2
3	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,330	1,330	3
4	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	10,506	10,506	4
5	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	54,147	54,147	5
6	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	13,164	13,164	6
7	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	10,344	10,344	7
8	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,931	1,931	8
9	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	3,788	3,788	9
10	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	270	270	10
11	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	149	149	11
12	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	80	80	12
13	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	40	40	13
14	Total			\$ 228,000			\$ 102,125	\$ * (125,875)	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%	\$ 148	\$ 148	15
16	V	26	LIABILITY INSURANCE	30,400	RISA	25.00%	30,400		16
17	V	34	BUILDING RENT	273,600	BARRY HOLDING COMPANY LLC	100.00%		(273,600)	17
18	V	30	DEPRECIATION		BARRY HOLDING COMPANY LLC	100.00%	12,012	12,012	18
19	V	32	INTEREST EXPENSE		BARRY HOLDING COMPANY LLC	100.00%	60,256	60,256	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			\$ 304,000			\$ 102,816	\$ * (201,184)	39

* 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 CTR # 0017590 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	\$ 8,644	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,862	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,506		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 CTR # 0017590 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 63201
Phone Number (636) 394-3000
Fax Number (636) 394-7713

	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				\$	\$	5,712,687	\$	1
2		ST GENEVIEVE CARE CTR						2,736,922		2
3		CCC OF LEMAY						2,734,877		3
4		SALEM CARE CENTER						1,990,818		4
5		MONMOUTH NH						2,857,134		5
6		MAR-KA NH						2,854,966		6
7		CCC OF SENECA						3,366,439		7
8		MT VERNON PLACE CARE						3,033,296		8
9		COUNTRY VIEW NH						2,441,372		9
10		MERAMEC NH						2,849,994		10
11		SEVILLE CARE CENTER						3,544,114		11
12		SALEM RES CARE						615,589		12
13		CARL JUNCTION RES CARE						710,870		13
14		MT VERNON RES CARE						483,587		14
15		SENECA HOME PLACE						453,327		15
16		HUDSON HOUSE						578,540		16
17		MAPLE GROVE LODGE						3,621,305		17
18		CCC OF AURORA						4,611,039		18
19		BARRY COMMUNITY CARE						3,247,414		19
20		LICKING RESIDENTIAL CTR						402,502		20
21		CCC OF GAINESVILLE						3,503,568		21
22		AL OF SILVER CREEK						775,678		22
23		MARK TWAIN MANOR						5,904,401		23
24		CCC OF LICKING						2,675,286		24
25	TOTALS					\$	\$		\$	25

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

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 63201
Phone Number (636) 394-3000
Fax Number (636) 394-7713

	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		COMMUNITY IN HOME				\$	\$	1,035,825	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	CFS CORP FLEET SERVICES		X	LEASE/PURCH BUS	\$975.17	4/8/11	\$ 51,580	\$ 38,611	4/8/17	11.4780	\$ 4,864	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	FIRST NAT'L BANK OF BARRY		X	WORKING CAP-LOC		VAR	VAR	436,553		VAR	22,622	6	
7	MISC INTEREST		X								154	7	
8												8	
9	TOTAL Facility Related				\$975.17		\$ 51,580	\$ 475,164			\$ 27,640	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 51,580	\$ 475,164			\$ 27,640	15	

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

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

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
BARRY COMMUNITY CARE CTR

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 46-031-09	RNG/BLK:6 TWP:04 SECT/LOT:25	\$ 49,943.00	\$ 49,943.00
2.	PT S SIDE NE	\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 49,943.00	\$ 49,943.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

- 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	FACILITY	5.04 ACRES	1973	\$ 20,739	1
2					2
3	TOTALS	#VALUE!		\$ 20,739	3

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW WINDOWS	2006	\$ 2,264	\$ 226	10	\$ 226	\$	\$ 1,452	37
38	FLOORING DINING ROOM	2006	3,677	368	10	368		2,575	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		14,075	41
42	ADDL SPRINKLER SYSTEM	2008	7,825	783	10	783		3,783	42
43	FLOORING	2010	1,325	132	10	132		385	43
44	8 REPLACEMENT WINDOWS	2010	1,265	126	10	126		273	44
45	5 TON 13-SEER A/C SYSTEM	2011	3,744	1,248	LEASE LIFE	1,248		2,496	45
46	ASPHALT SEALING	2011	3,003	1,060	LEASE LIFE	1,060		1,502	46
47	CONCRETE SIDEWALKS	2011	2,774	1,074	LEASE LIFE	1,074		1,253	47
48	ELECTRIC COMMERCIAL WATER HEATER 85 GAL	2011	4,817	1,927	LEASE LIFE	1,927		2,087	48
49	VINYL SIDING, GUTTER EDGE OF ROOF	2012	13,346	5,522	LEASE LIFE	5,522		5,522	49
50	MIXING VALVE FOR WATER HEATER	2012	1,470	608	LEASE LIFE	608		608	50
51	BACKFLOW PREVENTION DEVICE	2012	7,400	779	LEASE LIFE	779		779	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)		\$ 1,031,212	\$ 24,230		\$ 23,798	\$ (432)	\$ 969,511	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	\$299,632	\$11,996	\$11,996	\$	VAR	\$241,308	71
72	Current Year Purchases	1,150	144	144		VAR	144	72
73	Fully Depreciated Assets	121,534					121,534	73
74								74
75	TOTALS	\$422,316	\$12,140	\$12,140	\$		\$362,986	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			22,566	77
78										78
79										79
80	TOTALS			\$70,755	\$12,895	\$12,895	\$		\$41,741	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)	\$1,545,022	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$49,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$48,833	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(432)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,374,238	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

**

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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES
☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☒
HOURS PER CNA111

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☒
HOURS PER CNA48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,172	\$	1,172
2	Books and Supplies		300		300
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	\$	1,472	\$	1,472
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,472		

C. CONTRACTUAL INCOME

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

\$N/A

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$ 104,409	\$ 1,412		\$ 105,821	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs			14,130	173		14,303	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs			117,014	1,603		118,617	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	TOTAL			\$		\$ 235,553	\$ 3,188		\$ 238,741	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.

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	\$ 7,699	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,112,288		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,263		6
7	Other Prepaid Expenses	20,634		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)	\$ 2,769,312	\$	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	36,554		15
16	Equipment, at Historical Cost	493,071		16
17	Accumulated Depreciation (book methods)	(413,974)		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)	\$ 120,451	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,889,763	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 209,524	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	436,553		29
30	Accrued Salaries Payable	90,788		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,447		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 TO/FROM RP; ACC MGMT FEES	1,561,000		36
37	PT FUNDS/UNEARNED INCOME	174,275		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,515,427	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	38,611		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)	\$ 38,611	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,554,038	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 335,725	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,889,763	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 533,222	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 533,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(152,497)	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)	\$ (152,497)	17
	B. Transfers (Itemize):		
18	PY ADJ BAD DEBT ALLOW	(45,000)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (45,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 335,725	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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 17,292,232	1
2	Discounts and Allowances for all Levels	(14,792,673)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,499,559	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	588,625	6
7	Oxygen	159,328	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 747,953	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,069	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,750	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,819	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,091	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,091	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC REBATES 13,250; RESIDENT TRAVEL 66	13,316	28
28a	MISC STATE CORP TAX REFUND	6,396	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,712	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,296,134	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	689,458	31
32	Health Care	1,509,819	32
33	General Administration	681,771	33
B. Capital Expense			
34	Ownership	392,733	34
C. Ancillary Expense			
35	Special Cost Centers	8,454	35
36	Provider Participation Fee	166,396	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,448,631	40
41	Income before Income Taxes (line 30 minus line 40)**	(152,497)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (152,497)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income TAX
Tax Return? NO If not, please attach a reconciliation. DEPRECIATION
*** See the instructions. If this total amount has not been offset against int DIFFERENCE
expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,676	1,820	\$ 47,499	\$ 26.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,284	9,852	224,002	22.74	3
4	Licensed Practical Nurses	13,990	15,015	242,018	16.12	4
5	CNAs & Orderlies	47,915	50,803	532,327	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,940	2,156	28,565	13.25	9
10	Activity Assistants	1,740	1,812	14,739	8.13	10
11	Social Service Workers	2,060	2,184	28,454	13.03	11
12	Dietician					12
13	Food Service Supervisor	3,052	3,252	38,686	11.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,923	5,120	53,792	10.51	15
16	Dishwashers	10,554	11,059	100,186	9.06	16
17	Maintenance Workers	1,969	2,105	35,155	16.70	17
18	Housekeepers	11,850	12,414	117,715	9.48	18
19	Laundry	3,710	3,998	39,169	9.80	19
20	Administrator	1,816	2,080	63,743	30.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,918	2,170	32,877	15.15	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	1,869	2,037	21,776	10.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,266	127,877	\$ 1,620,703 *	\$ 12.67	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	83	\$ 3,129	1.3	35
36	Medical Director	96	6,000	9.3	36
37	Medical Records Consultant	40	2,290	10.3	37
38	Nurse Consultant		395	10.3	38
39	Pharmacist Consultant	96	4,012	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	24	2,180	11.3	44
45	Social Service Consultant	24	2,180	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	363	\$ 20,186		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

0017590

Report Period Beginning:

1/1/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

BARRY COMMUNITY CARE CTR

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>PATRICIA HUBBARD</td> <td>ADMINISTRATOR</td> <td>0</td> <td>\$ 63,743</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 63,743</td> </tr> </table>				Name	Function	Ownership %	Amount	PATRICIA HUBBARD	ADMINISTRATOR	0	\$ 63,743																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,743	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>Workers' Compensation Insurance</td> <td>\$ 48,004</td> </tr> <tr> <td>Unemployment Compensation Insurance</td> <td> </td> </tr> <tr> <td>FICA Taxes</td> <td>137,076</td> </tr> <tr> <td>Employee Health Insurance</td> <td>37,788</td> </tr> <tr> <td>Employee Meals</td> <td> </td> </tr> <tr> <td>Illinois Municipal Retirement Fund (IMRF)*</td> <td> </td> </tr> <tr> <td>OTHER EMPLOYEE BENEFITS</td> <td>5,472</td> </tr> <tr> <td>401K CONTRIBUTION</td> <td>2,038</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>HOME OFFICE ALLOCATION</td> <td>10,344</td> </tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 240,722</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 48,004	Unemployment Compensation Insurance		FICA Taxes	137,076	Employee Health Insurance	37,788	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		OTHER EMPLOYEE BENEFITS	5,472	401K CONTRIBUTION	2,038							HOME OFFICE ALLOCATION	10,344			TOTAL (agree to Schedule V, line 22, col.8)		\$ 240,722	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr> <td>IDPH License Fee</td> <td>\$ </td> </tr> <tr> <td>Advertising: Employee Recruitment</td> <td>871</td> </tr> <tr> <td>Health Care Worker Background Check (Indicate # of checks performed 16)</td> <td>489</td> </tr> <tr> <td>Patient Background Checks</td> <td> </td> </tr> <tr> <td>DUES & SUBSCRIPTIONS</td> <td>3,803</td> </tr> <tr> <td>TAXES & LICENSES</td> <td>1,574</td> </tr> <tr> <td>ADVERTISING-OTHER</td> <td>4,509</td> </tr> <tr> <td>ADVERTISING-YELLOW PAGES</td> <td>478</td> </tr> <tr> <td>HOME OFFICE ALLOCATION</td> <td>80</td> </tr> <tr> <td>Less: Public Relations Expense (</td> <td> </td> </tr> <tr> <td>Non-allowable advertising</td> <td>(4,509)</td> </tr> <tr> <td>Yellow page advertising</td> <td>(478)</td> </tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 6,817</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	871	Health Care Worker Background Check (Indicate # of checks performed 16)	489	Patient Background Checks		DUES & SUBSCRIPTIONS	3,803	TAXES & LICENSES	1,574	ADVERTISING-OTHER	4,509	ADVERTISING-YELLOW PAGES	478	HOME OFFICE ALLOCATION	80	Less: Public Relations Expense (		Non-allowable advertising	(4,509)	Yellow page advertising	(478)			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,817
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HFS 3745 (N-4-99)

IL478-2471

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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?

YES

What was the average life used for new equipment added during this period?

3-10 YTS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

12,355

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.

\$

166,396

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?

45%

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 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?

Attach invoices and a summary of services for all architect and appraisal fees.