FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0017590

Facility Name: BARRY COMMUNITY CARE CENTER

Address: 1313 PRATT STREET (Number) BARRY (City) 62312 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	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 1/1/14 to 12/31/14 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) CAMILLE B. LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801
(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 CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,173	5,906	1,897	18,976	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,173	5,906	1,897	18,976	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.41%

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 [X]

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

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 [X] Date 6/1/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 76 and days of care provided 1,699

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	188,322	15,639	5,555	209,516		209,516		209,516			1
2	Food Purchase		116,710		116,710		116,710	(10,492)	106,218			2
3	Housekeeping	92,001	13,312		105,313		105,313	150	105,463			3
4	Laundry	51,176	12,583		63,759		63,759		63,759			4
5	Heat and Other Utilities			76,030	76,030		76,030		76,030			5
6	Maintenance	40,973	8,628	23,675	73,276		73,276	77	73,353			6
7	Other (specify):*											7
8	TOTAL General Services	372,472	166,872	105,260	644,604		644,604	(10,265)	634,339			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,065,526	52,640	6,085	1,124,251		1,124,251	10,771	1,135,022			10
10a	Therapy		318	334,466	334,784		334,784		334,784			10a
11	Activities	35,557	882	2,068	38,507		38,507		38,507			11
12	Social Services	25,921		2,142	28,063		28,063		28,063			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,127,004	53,840	350,761	1,531,605		1,531,605	10,771	1,542,376			16
	C. General Administration											
17	Administrative	64,418			64,418		64,418	11,118	75,536			17
18	Directors Fees			2,400	2,400		2,400		2,400			18
19	Professional Services			150,979	150,979		150,979	(124,175)	26,804			19
20	Dues, Fees, Subscriptions & Promotions			8,491	8,491		8,491	(2,210)	6,281			20
21	Clerical & General Office Expenses	34,713	4,828	35,231	74,772		74,772	48,784	123,556			21
22	Employee Benefits & Payroll Taxes			227,494	227,494		227,494	9,583	237,077			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,857	10,857		10,857	1,818	12,675			24
25	Other Admin. Staff Transportation							302	302			25
26	Insurance-Prop.Liab.Malpractice			37,982	37,982		37,982	45	38,027			26
27	Other (specify):*											27
28	TOTAL General Administration	99,131	4,828	473,434	577,393		577,393	(54,735)	522,658			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,598,607	225,540	929,455	2,753,602		2,753,602	(54,229)	2,699,373			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER #0017590 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			35,045	35,045		35,045	10,401	45,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,291	23,291		23,291	45,317	68,608			32
33	Real Estate Taxes			55,644	55,644		55,644		55,644			33
34	Rent-Facility & Grounds			273,600	273,600		273,600	(266,983)	6,617			34
35	Rent-Equipment & Vehicles			52	52		52	2,819	2,871			35
36	Other (specify):*											36
37	**TOTAL Ownership**			387,632	387,632		387,632	(208,446)	179,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			89,380	89,380		89,380		89,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,482	146,482		146,482		146,482			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			235,862	235,862		235,862		235,862			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,598,607	225,540	1,552,949	3,377,096		3,377,096	(262,675)	3,114,421			45

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,306)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,652)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	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	(3,133)	21		18
19	Entertainment				19
20	Contributions	(1,617)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,556)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(486)	20		28
29	Other-Attach Schedule	(1,580)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,516)		$	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 Amount	2 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)	(240,159)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (240,159)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (262,675)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			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

STATE OF ILLINOIS

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISCELLANEOUS INCOME	$ (1,148)	21	1
2	DEPRECIATION - CAP COST AUDIT ADJS pg 12	(432)	30	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,580)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	(10,492)	0	0	0	0	0	0	0	0	0	0	(10,492)	2
3	Housekeeping	0	0	150	0	0	0	0	0	0	0	0	150	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	77	0	0	0	0	0	0	0	0	0	77	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,492)	77	150	0	0	0	0	0	0	0	0	(10,265)	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	10,771	0	0	0	0	0	0	0	0	0	10,771	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	10,771	0	0	0	0	0	0	0	0	0	10,771	16
	C. General Administration													
17	Administrative	0	11,118	0	0	0	0	0	0	0	0	0	11,118	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(124,175)	0	0	0	0	0	0	0	0	0	(124,175)	19
20	Fees, Subscriptions & Promotions	(2,042)	(168)	0	0	0	0	0	0	0	0	0	(2,210)	20
21	Clerical & General Office Expenses	(5,898)	54,682	0	0	0	0	0	0	0	0	0	48,784	21
22	Employee Benefits & Payroll Taxes	0	9,583	0	0	0	0	0	0	0	0	0	9,583	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,818	0	0	0	0	0	0	0	0	0	1,818	24
25	Other Admin. Staff Transportation	0	302	0	0	0	0	0	0	0	0	0	302	25
26	Insurance-Prop.Liab.Malpractice	0	45	0	0	0	0	0	0	0	0	0	45	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,940)	(46,795)	0	0	0	0	0	0	0	0	0	(54,735)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,432)	(35,947)	150	0	0	0	0	0	0	0	0	(54,229)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(432)	0	10,833	0	0	0	0	0	0	0	0	10,401	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,652)	0	48,969	0	0	0	0	0	0	0	0	45,317	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,617	(273,600)	0	0	0	0	0	0	0	0	(266,983)	34
35	Rent-Equipment & Vehicles	0	2,819	0	0	0	0	0	0	0	0	0	2,819	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,084)	9,436	(213,798)	0	0	0	0	0	0	0	0	(208,446)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,516)	(26,511)	(213,648)	0	0	0	0	0	0	0	0	(262,675)	45

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	MONMOUTH	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. [X] 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	$ 124,800	COMMUNITY CARE CENTERS, INC.	100.00%	$	$ (124,800)	1
2	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	6,617	6,617	2
3	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,819	2,819	3
4	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	11,118	11,118	4
5	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	54,682	54,682	5
6	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	10,771	10,771	6
7	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	9,583	9,583	7
8	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	625	625	8
9	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,818	1,818	9
10	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	302	302	10
11	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	77	77	11
12	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	(168)	(168)	12
13	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	45	45	13
14	Total			$ 124,800			$ 98,289	$ * (26,511)	14

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. [X] 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)	
15	V	3	HOME OFFICE/MGMT FEES	$	COMMUNITY CARE CENTERS, INC.	100.00%	$ 150	$ 150	15
16	V	26	LIABILITY INSURANCE	26,600	RISA	25.00%	26,600		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%	10,833	10,833	18
19	V	32	INTEREST EXPENSE		BARRY HOLDING COMPANY LLC	100.00%	48,969	48,969	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			$ 300,200			$ 86,552	$ * (213,648)	39

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: 1/1/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	3	6.00	SALARY	$ 8,759	17.7	1
2	JESSICA CRANE	SECRETARY			NONE	2	5.00	SALARY	2,359	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	$ 11,118		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: 1/1/14 Ending: 12/31/14

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 [X] 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				$	$	5,531,350	$	1
2		ST GENEVIEVE CARE CTR						2,756,639		2
3		CCC OF LEMAY						2,724,094		3
4		SALEM CARE CENTER						1,893,145		4
5		MONMOUTH NH						2,826,453		5
6		MAR-KA NH						2,921,273		6
7		CCC OF SENECA						3,304,709		7
8		MT VERNON PLACE CARE						2,975,734		8
9		COUNTRY VIEW NH						2,391,841		9
10		MERAMEC NH						2,849,145		10
11		SEVILLE CARE CENTER						3,583,655		11
12		SALEM RES CARE						635,057		12
13		CARL JUNCTION RES CARE						710,916		13
14		MT VERNON RES CARE						452,196		14
15		SENECA HOME PLACE						498,180		15
16		HUDSON HOUSE						595,650		16
17		MAPLE GROVE LODGE						3,104,434		17
18		CCC OF AURORA						4,344,828		18
19		BARRY COMMUNITY CARE						3,242,953		19
20		LICKING RESIDENTIAL CTR						400,529		20
21		CCC OF GAINESVILLE						3,386,138		21
22		AL OF SILVER CREEK						797,826		22
23		MARK TWAIN MANOR						6,279,125		23
24		CCC OF LICKING						2,623,355		24
25	TOTALS					$	$		$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 [X] NO [ ]

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

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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				$	$	1,013,495	$	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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CFS CORP FLEET SERVICES		X	LEASE/PURCH BUS	$975.17	4/8/11	$ 51,580	$ 22,354	4/8/17	11.4780	$ 3,109	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST NAT'L BANK OF BARRY		X	WORKING CAP-LOC		VAR	VAR	417,289		VAR	20,182	6
7												7
8												8
9	TOTAL Facility Related				$975.17		$ 51,580	$ 439,643			$ 23,291	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	$ 439,643			$ 23,291	15

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

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

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 55,644	2
3. Under or (over) accrual (line 2 minus line 1).		$ 20,804	3
4. Real Estate Tax accrual used for 2014 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.		$ 55,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	46,623	8
	2010	47,948	9
	2011	49,943	10
	2012	56,087	11
	2013	55,644	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	46-031-09	RNG/BLK:6 TWP:04 SECT/LOT:25	$ 55,644.00	$ 55,644.00
2.		PT S SIDE NE	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,644.00	$ 55,644.00

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 X _____ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 1/1/14 Ending: 12/31/14

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 [X] (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? [X] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	5.04 ACRES	1973	$ 20,739	1
2					2
3	TOTALS	5.04 ACRES		$ 20,739	3

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		Feb-75	1975	$ 805,055	$	30	$	$	$ 805,055	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO			1976	936		20			936	9
10	DRIVE			1987	3,002	95	31	95		2,610	10
11	ROOF			1995	27,030		51			27,030	11
12	BLACKTOP DRIVE			1998	6,300		15			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											18
19	AMER STANDARD 15T RFTOP A/C			2004	11,475	382	10	382		11,475	19
20	85-GALLON WATER HEATER			2005	5,016	502	10	502		4,765	20
21	CARPET-FOYER, OFFICES			2005	5,373		5			5,373	21
22	TILE FLOORING DIN RM, LV RM			2005	5,598	560	10	560		5,178	22
23	PAINTING			2005	15,490	1,549	10	1,549		13,941	23
24	WAINSCOTING			2005	4,187	419	10	419		3,768	24
25	CEILING LIGHT FIXTURES (REMOVED CAP DESK AUDIT 2008)			2005		112			(112)		25
26	WALLPAPER			2005	8,958	896	10	896		8,062	26
27	OUTDOOR LIGHTS (REMOVED CAP DESK AUDIT 2008)			2005		119			(119)		27
28	LANDSCAPING			2005	7,080	708	10	708		6,490	28
29	BRICK SIGN			2005	4,895	490	10	490		4,446	29
30	CONCRETE WORK			2005	1,931	129	15	129		1,170	30
31	LANDSCAPING (REMOVED CAP DESK AUDIT 2008)			2006		102			(102)		31
32	CONCRETE WORK			2006	4,625	308	15	308		2,492	32
33	RE-ROOF FRONT ENTRANCE			2006	1,592	159	10	159		1,433	33
34	HALL LIGHTS (REMOVED CAP DESK AUDIT 2008)			2006		99			(99)		34
35	NEW WINDOWS			2006	2,172	217	10	217		1,937	35
36	NEW WINDOWS			2006	2,264	226	10	226		1,906	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: 1/1/14 Ending: 12/31/14

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	FLOORING DINING ROOM	2006	$ 3,677	$ 368	10	$ 368	$	$ 3,309	37
38	SS WALLCOVERING BEHIND STOVE	2006	1,408		5			1,408	38
39	FIREPROOFING & FIREWALLS	2006	1,900		5			1,900	39
40	FIRE ALARM SYSTEM	2007	23,455	2,351	10	2,351		18,764	40
41	ADDL SPRINKLER SYSTEM	2008	7,825	783	10	783		5,347	41
42	FLOORING	2010	1,325	132	10	132		651	42
43	8 REPLACEMENT WINDOWS	2010	1,265	126	10	126		527	43
44	5 TON 13-SEER A/C SYSTEM	2011	3,744		LEASE LIFE			3,744	44
45	ASPHALT SEALING	2011	3,003	442	LEASE LIFE	442		3,003	45
46	CONCRETE SIDEWALKS	2011	2,774	448	LEASE LIFE	448		2,774	46
47	ELECTRIC COMMERCIAL WATER HEATER 85 GAL	2011	4,817	803	LEASE LIFE	803		4,817	47
48	VINYL SIDING, GUTTER EDGE OF ROOF	2012	13,346	2,301	LEASE LIFE	2,301		13,346	48
49	MIXING VALVE FOR WATER HEATER	2012	1,470	254	LEASE LIFE	254		1,470	49
50	BACKFLOW PREVENTION DEVICE	2012	7,400	1,947	LEASE LIFE	1,947		7,400	50
51	ALARM SYSTEM CPU	2013	1,409	704	8	704		1,409	51
52	VINYL FLOORING FOYER, OFFICE	2014	2,200	2,200	3	2,200		2,200	52
53	WATER SOFTENING UNIT	2014	14,700	2,520	35	2,520		2,520	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)		$ 1,049,521	$ 22,451		$ 22,019	$ (432)	$ 1,019,780	70

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 302,416	$ 9,817	$ 9,817	$	VAR	$ 261,253	71
72	Current Year Purchases	7,307	715	715		VAR	715	72
73	Fully Depreciated Assets	121,534					121,534	73
74								74
75	TOTALS	$ 431,257	$ 10,532	$ 10,532	$		$ 383,502	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			48,356	77
78										78
79										79
80	TOTALS			$ 70,755	$ 12,895	$ 12,895	$		$ 67,531	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)	$ 1,572,272	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,878	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,446	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)	$ 1,470,813	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.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 52 Description: Trinity Rental
    (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: 1/1/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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 CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	10.a2&3	hrs	$		$ 141,901	$ 106		$ 142,007	1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs			16,614			16,614	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.a2&3	hrs			175,951	212		176,163	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 prescrpts				84,687		84,687	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB & XRAY	39.3					4,693		4,693	12
13	Other (specify):									13
14	TOTAL			$		$ 334,466	$ 89,698		$ 424,164	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: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 48,616	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	725,866		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,776		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)**	$ 2,425,320	$	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	54,863		15
16	Equipment, at Historical Cost	502,012		16
17	Accumulated Depreciation (book methods)	(488,717)		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)**	$ 72,958	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,498,278	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 324,110	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	417,269		29
30	Accrued Salaries Payable	93,654		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,174		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	1,678,800		36
37	PT FUNDS/UNEARNED INCOME	74,823		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,630,670	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,354		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)**	$ 22,354	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,653,024	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (154,746)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,498,278	$	48

***(See instructions.)**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,119	1	
2	Restatements (describe):		2	
3	ROUNDING	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,121	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(165,867)	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)**	$ (165,867)	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)**	$ (154,746)	24	*

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,149,225	1
2	Discounts and Allowances for all Levels	(13,963,709)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,185,516	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	840,100	6
7	Oxygen	170,507	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,010,607	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	10,306	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,652	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,652	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC REBATES	1,148	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,148	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,211,229	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	644,604	31
32	Health Care	1,531,605	32
33	General Administration	577,393	33
	B. Capital Expense		
34	Ownership	387,632	34
	C. Ancillary Expense		
35	Special Cost Centers	89,380	35
36	Provider Participation Fee	146,482	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,377,096	40
41	**Income before Income Taxes (line 30 minus line 40)****	(165,867)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (165,867)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,298,305	44
45	Private Pay - Net Inpatient Revenue	997,191	45
46	Medicare - Net Inpatient Revenue	182,680	46
47	Other-(specify) HOSPICE	232	47
48	Other-(specify) BAD DEBTS/PY CONTR ADJS	(292,892)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,185,516	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: 1/1/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,811	1,883	$ 53,283	$ 28.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,968	7,544	181,480	24.06	3
4	Licensed Practical Nurses	13,020	13,972	253,899	18.17	4
5	CNAs & Orderlies	48,534	51,474	554,725	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,008	19,803	9.86	9
10	Activity Assistants	1,351	1,467	15,754	10.74	10
11	Social Service Workers	1,774	1,902	25,921	13.63	11
12	Dietician					12
13	Food Service Supervisor	2,090	2,194	24,288	11.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,300	4,620	51,109	11.06	15
16	Dishwashers	11,596	12,019	112,926	9.40	16
17	Maintenance Workers	2,253	2,289	40,973	17.90	17
18	Housekeepers	8,262	8,882	92,001	10.36	18
19	Laundry	4,525	5,045	51,176	10.14	19
20	Administrator	1,872	2,080	64,418	30.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,001	2,153	34,713	16.12	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	1,784	1,958	22,138	11.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,013	121,490	$ 1,598,607 *	$ 13.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	152	$ 5,520	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				38
39	Pharmacist Consultant	96	4,205	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	2,018	11.3	44
45	Social Service Consultant	26	2,142	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	426	$ 21,765		49

C. CONTRACT NURSES

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PATRICIA HUBBARD	ADMINISTRATOR	0	$ 64,418
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,418

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE CENTERS	MGMT FEES	$ 124,800
BKD, LLP	ACCOUNTING	9,035
PIKE COUNTY CLRC CLRK	LEGAL	160
ROSENBLUM GOLDENHERSH	LEGAL	3,214
RISK INS	LEGAL	13,380
CT CORPORATION	LEGAL	365
ADMIN-AMANDA DOLBEARE	LEGAL	25
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 150,979

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,981
Unemployment Compensation Insurance	
FICA Taxes	143,756
Employee Health Insurance	34,545
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	5,880
401K CONTRIBUTION	2,686
OSHA EMPLOYEES BENEFITS	158
WORKER'S COMP-PRIOR	(5,512)
HOME OFFICE ALLOCATION	9,583
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,077

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,613
Health Care Worker Background Check	
(Indicate # of checks performed 19)	632
Patient Background Checks	
DUES & SUBSCRIPTIONS	2,865
TAXES & LICENSES	1,339
ADVERTISING-YELLOW PGS &OTHER	2,042
HOME OFFICE ALLOCATION	(168)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,556)
Yellow page advertising	(486)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,281

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,478
PATIENT	5,036
Seminar Expense	3,343
HOME OFFICE ALLOCATION	1,818
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,675

**See instructions.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 $3,496**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,393** 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. $ **146,482**
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? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **67%**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.