



Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590** Report Period Beginning: **1/1/17** Ending: **12/31/17**

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

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

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,650	5,854	1,518	18,022	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,650	5,854	1,518	18,022	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.97%**

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve days in Section B.)

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**

NONE

**F. Does the facility maintain a daily midnight census?** YES

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

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

**I. On what date did you start providing long term care at this location?**  
Date started 2/22/75

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 6/1/2011 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 76 and days of care provided 1,281

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, IN** # **0017590** Report Period Beginning: **1/1/17** Ending: **12/31/17**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	187,197	12,281	5,619	205,097		205,097		205,097		1
2	Food Purchase		118,719		118,719		118,719	(6,472)	112,247		2
3	Housekeeping	102,493	13,058		115,551		115,551	163	115,714		3
4	Laundry	47,535	10,466		58,001		58,001		58,001		4
5	Heat and Other Utilities			78,390	78,390		78,390		78,390		5
6	Maintenance	44,872	16,777	40,774	102,423		102,423	82	102,505		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>382,097</b>	<b>171,301</b>	<b>124,783</b>	<b>678,181</b>		<b>678,181</b>	<b>(6,227)</b>	<b>671,954</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,084,168	53,499	5,830	1,143,497		1,143,497	5,699	1,149,196		10
10a	Therapy			194,794	194,794		194,794		194,794		10a
11	Activities	28,595	467	2,022	31,084		31,084		31,084		11
12	Social Services	40,484	15	2,022	42,521		42,521		42,521		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			1,109	1,109		1,109		1,109		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,153,247</b>	<b>53,981</b>	<b>211,777</b>	<b>1,419,005</b>		<b>1,419,005</b>	<b>5,699</b>	<b>1,424,704</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	65,894			65,894		65,894	10,445	76,339		17
18	Directors Fees			2,400	2,400		2,400		2,400		18
19	Professional Services			132,602	132,602		132,602	(123,260)	9,342		19
20	Dues, Fees, Subscriptions & Promotions			15,744	15,744		15,744	(1,318)	14,426		20
21	Clerical & General Office Expenses	25,105	6,025	50,628	81,758		81,758	43,738	125,496		21
22	Employee Benefits & Payroll Taxes			213,323	213,323		213,323	6,843	220,166		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,569	4,569		4,569	1,302	5,871		24
25	Other Admin. Staff Transportation							401	401		25
26	Insurance-Prop.Liab.Malpractice			18,281	18,281		18,281	37	18,318		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>90,999</b>	<b>6,025</b>	<b>437,547</b>	<b>534,571</b>		<b>534,571</b>	<b>(61,812)</b>	<b>472,759</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,626,343</b>	<b>231,307</b>	<b>774,107</b>	<b>2,631,757</b>		<b>2,631,757</b>	<b>(62,340)</b>	<b>2,569,417</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

BARRY COMMUNITY CARE CENTER, INC.

#0017590

Report Period Beginning:

1/1/17

Ending:

12/31/17

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			13,813	13,813		13,813	1,574	15,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,918	2,918		2,918	35,604	38,522			32
33	Real Estate Taxes			60,941	60,941		60,941		60,941			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(221,314)	6,686			34
35	Rent-Equipment & Vehicles			1,130	1,130		1,130	1,136	2,266			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			306,802	306,802		306,802	(183,000)	123,802			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			83,632	83,632		83,632		83,632			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,230	143,230		143,230		143,230			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			226,862	226,862		226,862		226,862			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,626,343	231,307	1,307,771	3,165,421		3,165,421	(245,340)	2,920,081			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,277)	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	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(195)	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	(7,221)	21		18
19	Entertainment				19
20	Contributions	(1,507)	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	(1,176)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(276)	20		28
29	Other-Attach Schedule	(4,335)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (21,012)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(224,328)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (224,328)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (245,340)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

BARRY COMMUNITY CARE CENTER, INC.

ID# 0017590

Report Period Beginning: 1/1/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	MISCELLANEOUS INCOME	\$	(4,273)	21 1
2	TRAVEL & SEMINARS MEALS		(62)	24 2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(4,335)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC.# 0017590

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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	(6,472)	0	0	0	0	0	0	0	0	0	0	(6,472)	2
3	Housekeeping	0	0	163	0	0	0	0	0	0	0	0	163	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	82	0	0	0	0	0	0	0	0	0	82	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,472)</b>	<b>82</b>	<b>163</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,227)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,699	0	0	0	0	0	0	0	0	0	5,699	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5,699</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,699</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	10,445	0	0	0	0	0	0	0	0	0	10,445	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(123,260)	0	0	0	0	0	0	0	0	0	(123,260)	19
20	Fees, Subscriptions & Promotions	(1,452)	134	0	0	0	0	0	0	0	0	0	(1,318)	20
21	Clerical & General Office Expenses	(13,001)	56,739	0	0	0	0	0	0	0	0	0	43,738	21
22	Employee Benefits & Payroll Taxes	0	6,843	0	0	0	0	0	0	0	0	0	6,843	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(62)	1,364	0	0	0	0	0	0	0	0	0	1,302	24
25	Other Admin. Staff Transportation	0	401	0	0	0	0	0	0	0	0	0	401	25
26	Insurance-Prop.Liab.Malpractice	0	37	0	0	0	0	0	0	0	0	0	37	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(14,515)</b>	<b>(47,297)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(61,812)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(20,987)</b>	<b>(41,516)</b>	<b>163</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(62,340)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	1,574	0	0	0	0	0	0	0	0	1,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	0	35,629	0	0	0	0	0	0	0	0	35,604	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,686	(228,000)	0	0	0	0	0	0	0	0	(221,314)	34
35	Rent-Equipment & Vehicles	0	1,136	0	0	0	0	0	0	0	0	0	1,136	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	(25)	7,822	(190,797)	0	0	0	0	0	0	0	0	(183,000)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	(21,012)	(33,694)	(190,634)	0	0	0	0	0	0	0	0	(245,340)	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	MONMOUTH	COMMUNITY CARE CENTERS	BALLWIN, MO	HOME OFFICE
		MAR-KA NURSING HOME	MASCOUHAH	RISA	JEFFERSON CITY, MO	LIAB INS
				BARRY HOLDING COMPANY, LLC	BALLWIN, MO	FACILITY LEASE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 HOME OFFICE/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%	6,686	6,686	2
3	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,136	1,136	3
4	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	10,445	10,445	4
5	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	56,739	56,739	5
6	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	5,699	5,699	6
7	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	6,843	6,843	7
8	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,540	1,540	8
9	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,364	1,364	9
10	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	401	401	10
11	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	82	82	11
12	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	134	134	12
13	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	37	37	13
14	Total		\$ 124,800			\$ 91,106	\$ * (33,694)	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%	\$ 163	\$ 163
16	V	26 LIABILITY INSURANCE	5,700	RISA	25.00%	5,700	
17	V	34 BUILDING RENT	228,000	BARRY HOLDING COMPANY LLC	100.00%		(228,000)
18	V	30 DEPRECIATION		BARRY HOLDING COMPANY LLC	100.00%	1,574	1,574
19	V	32 INTEREST EXPENSE		BARRY HOLDING COMPANY LLC	100.00%	35,629	35,629
20	V	5 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%		
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 233,700			\$ 43,066	\$ * (190,634)

\* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0	\$ *

\* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0	\$ *

\* 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		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	<b>Total</b>		\$			\$	0	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0	\$ *

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0	\$ *

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





Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, II** # **0017590** Report Period Beginning: **1/1/17** Ending: **12/31/17**

## 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	2	4.00	SALARY	\$ 8,242	17.7	1
2	MARY SCAPER	SECRETARY			NONE	3	8.00	SALARY	2,202	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	\$ 10,444		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, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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				\$	\$	5,531,326	\$	1
2	ST GENEVIEVE CARE CTR						3,169,059		2
3	CCC OF LEMAY						3,046,408		3
4	SALEM CARE CENTER						1,999,878		4
5	MONMOUTH NH						2,736,463		5
6	MAR-KA NH						2,929,733		6
7	CCC OF SENECA						3,316,587		7
8	MT VERNON PLACE CARE						2,812,326		8
9	COUNTRY VIEW NH						2,264,521		9
10	MERAMEC NH						3,198,319		10
11	SEVILLE CARE CENTER						3,343,167		11
12	SALEM RES CARE						616,000		12
13	CARL JUNCTION RES CARE						702,842		13
14	MT VERNON RES CARE						468,962		14
15	SENECA HOME PLACE						342,677		15
16	HUDSON HOUSE						667,073		16
17	MAPLE GROVE LODGE						3,351,069		17
18	CCC OF AURORA						4,620,953		18
19	BARRY COMMUNITY CARE						3,065,538		19
20	LICKING RESIDENTIAL CTR						388,318		20
21	CCC OF GAINESVILLE						3,212,048		21
22	AL OF SILVER CREEK						928,816		22
23	MARK TWAIN MANOR						6,265,445		23
24	CCC OF LICKING						2,136,110		24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	COMMUNITY IN HOME				\$	\$	999,199	\$	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, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

**1/1/17**

Ending: **12/31/17**

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, IN** # **0017590** Report Period Beginning: **1/1/17** Ending: **12/31/17**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	CFS CORP FLEET SERVICES		X	LEASE/PURCHASE BUS	\$975.17	4/8/11	\$ 51,580		4/8/17	11.4780	\$ 1,003	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	FIRST NAT'L BANK OF BARRY	X		WORKING CAP-LOC		VAR	VAR			VAR	1,037	6						
7	DELAGE LINDEN		X	SAVIN COPIER LEASE	\$169.17	2/10/15	4,530	252	2/10/18	31.1900	436	7						
8	WORK COMP FINANCING		X								442	8						
9	TOTAL Facility Related				\$1,144.34		\$ 56,110	\$ 252			\$ 2,918	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 56,110	\$ 252			\$ 2,918	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.)



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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<b>34,840</b>	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.)		\$	<b>60,941</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>26,101</b>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>34,840</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>60,941</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<b>56,087</b>	8
	2013	<b>55,644</b>	9
	2014	<b>57,211</b>	10
	2015	<b>59,974</b>	11
	2016	<b>60,941</b>	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BARRY COMMUNITY CARE CENTER, INC. 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 2016 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 2016.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>46-031-09</u>	<u>RNG/BLK:6 TWP:04 SECT/LOT:25</u>	\$ <u>60,941.00</u>	\$ <u>60,941.00</u>
2. _____	<u>PT S SIDE NE</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>60,941.00</u>	\$ <u>60,941.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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.**

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2015 REAL ESTATE TAX COST DOCUMENTATION**

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BARRY COMMUNITY CARE CENTER, INC. COUNTY PIKE  
 FACILITY IDPH LICENSE NUMBER 0017590  
 CONTACT PERSON REGARDING THIS REPORT Yvonne Chua  
 TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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, INC.**

# **0017590** Report Period Beginning:

1/1/17 Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

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

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

Report Period Beginning:

1/1/17

Ending:

12/31/17

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		1975	1975	\$ 805,055	\$	30	\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		PATIO		1976	936		20			936	9
10		DRIVE		1987	3,002	95	31	95		2,895	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		10			11,475	19
20		85-GALLON WATER HEATER		2005	5,016		10			5,016	20
21		CARPET-FOYER, OFFICES		2005	5,373		5			5,373	21
22		TILE FLOORING DIN RM, LV RM		2005	5,598		10			5,598	22
23		PAINTING		2005	15,490		10			15,490	23
24		WAINSCOTING		2005	4,187		10			4,187	24
25		CEILING LIGHT FIXTURES (REMOVED CAP DESK AUDIT 2008)		2005							25
26		WALLPAPER		2005	8,958		10			8,958	26
27		OUTDOOR LIGHTS (REMOVED CAP DESK AUDIT 2008)		2005							27
28		LANDSCAPING		2005	7,080		10			7,080	28
29		BRICK SIGN		2005	4,895		10			4,895	29
30		CONCRETE WORK		2005	1,931	129	15	129		1,557	30
31		LANDSCAPING (REMOVED CAP DESK AUDIT 2008)		2006							31
32		CONCRETE WORK		2006	4,625	308	15	308		3,416	32
33		RE-ROOF FRONT ENTRANCE		2006	1,592		10			1,592	33
34		HALL LIGHTS (REMOVED CAP DESK AUDIT 2008)		2006							34
35		NEW WINDOWS		2006	2,172		10			2,172	35
36		NEW WINDOWS		2006	2,264		10			2,264	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, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOORING DINING ROOM	2006	\$ 3,677	\$	10	\$	\$	\$ 3,677	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		10			23,455	40
41	ADDL SPRINKLER SYSTEM	2008	7,825	783	10	783		7,696	41
42	FLOORING	2010	1,325	132	10	132		1,048	42
43	8 REPLACEMENT WINDOWS	2010	1,265	126	10	126		906	43
44	5 TON 13-SEER A/C SYSTEM	2011	3,744		LEASE LIFE			3,744	44
45	ASPHALT SEALING	2011	3,003		LEASE LIFE			3,003	45
46	CONCRETE SIDEWALKS	2011	2,774		LEASE LIFE			2,774	46
47	ELECTRIC COMMERCIAL WATER HEATER 85 GAL	2011	4,817		LEASE LIFE			4,817	47
48	VINYL SIDING, GUTTER EDGE OF ROOF	2012	13,346		LEASE LIFE			13,346	48
49	MIXING VALVE FOR WATER HEATER	2012	1,470		LEASE LIFE			1,470	49
50	BACKFLOW PREVENTION DEVICE	2012	7,400		LEASE LIFE			7,400	50
51	ALARM SYSTEM CPU	2013	1,409		LEASE LIFE			1,409	51
52	VINYL FLOORING FOYER, OFFICE	2014	2,200		LEASE LIFE			2,200	52
53	WATER SOFTENING UNIT	2014	14,700	2,100	LEASE LIFE	2,100		14,700	53
54	FIREWALL MODIFICATIONS	2015	5,601	1,001	LEASE LIFE	1,001		5,601	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)		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	70

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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



**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

Facility Name & ID Number **BARRY COMMUNITY CARE CENTER, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 1,055,122	\$ 4,674		\$ 4,674	\$	\$ 247,612

\*\*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	\$ 312,311	\$ 10,390	\$ 10,390	\$		\$ 290,838	71
72	Current Year Purchases	10,410	323	323			323	72
73	Fully Depreciated Assets	121,534					121,534	73
74								74
75	<b>TOTALS</b>	\$ 444,255	\$ 10,713	\$ 10,713	\$		\$ 412,695	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	2004	\$ 19,175	\$	\$	\$	4	\$ 19,175	76
77	2011 CHAMP 15-PAS BUS	2011	2011	51,580				4	51,580	77
78										78
79										79
80	<b>TOTALS</b>			\$ 70,755	\$	\$	\$		\$ 70,755	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)	\$ 1,590,871	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,387	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,387	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 731,062	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

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

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 1,130 Description: Copier/Scanner \$1,130

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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



Facility Name & ID Number BARRY COMMUNITY CARE CENTER, INC. # 0017590 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10.a2&3	hrs	\$	1,255	\$ 92,031	\$	1,255	\$ 92,031	1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		189	14,022		189	14,022	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.a2&3	hrs		1,271	88,741		1,271	88,741	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			76,885			76,885	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>LAB &amp; XRAY</u>	39.3				6,747			6,747	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	2,715	\$ 278,426	\$	2,715	\$ 278,426	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.

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

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (74,635)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	616,064		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,959		6
7	Other Prepaid Expenses	(5,382)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>INTERCO NOTE, DUE T/F CC</b>	99,539		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 638,545	\$	10
	<b>B. Long-Term Assets</b>			
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	60,464		15
16	Equipment, at Historical Cost	515,010		16
17	Accumulated Depreciation (book methods)	(538,913)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	74,704		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(53,884)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,800		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 62,181	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 700,726	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 304,397	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,557		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,632		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,840		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>DUE T/T BARRY HOLDING; ACC MGN</b>	1,808,094		36
37	<b>PT FUNDS/RETIREMENT FUND</b>	6,638		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,252,158	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>NOTE PAYABLE</b>	252		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 252	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,252,410	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,551,684)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 700,726	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,419,234)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,419,234)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(132,450)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(132,450)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,551,684)</b>	<b>24</b> *

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

Facility Name &amp; ID Number BARRY COMMUNITY CARE CENTER, INC.

# 0017590

Report Period Beginning: 1/1/17

Ending:

12/31/17

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,360,415	1
2	Discounts and Allowances for all Levels	(13,032,081)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,328,334	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	542,445	6
7	Oxygen	151,617	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 694,062	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,277	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,277	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	25	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 25	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>MISC REBATES</b>	4,273	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,273	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,032,971	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	678,181	31
32	Health Care	1,419,005	32
33	General Administration	534,571	33
<b>B. Capital Expense</b>			
34	Ownership	306,802	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	83,632	35
36	Provider Participation Fee	143,230	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,165,421	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(132,450)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (132,450)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,312,675	44
45	Private Pay - Net Inpatient Revenue	1,044,245	45
46	Medicare - Net Inpatient Revenue	121,878	46
47	Other-(specify) <b>HOSPICE</b>	22,242	47
48	Other-(specify) <b>BAD DEBTS/PY CONTR ADJS/Part B</b>	(172,706)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,328,334	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, INC.**

# **0017590**

Report Period Beginning:

1/1/17

Ending:

12/31/17

**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	2,051	2,099	\$ 66,573	\$ 31.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,537	6,871	180,248	26.23	3
4	Licensed Practical Nurses	12,761	13,489	279,942	20.75	4
5	CNAs & Orderlies	38,984	41,379	504,063	12.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,670	1,702	22,309	13.11	9
10	Activity Assistants	646	652	6,286	9.64	10
11	Social Service Workers	2,381	2,505	40,484	16.16	11
12	Dietician					12
13	Food Service Supervisor	2,397	2,566	33,897	13.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,927	7,335	85,616	11.67	15
16	Dishwashers	7,707	7,875	67,684	8.59	16
17	Maintenance Workers	2,568	2,688	44,872	16.69	17
18	Housekeepers	9,521	10,101	102,493	10.15	18
19	Laundry	3,604	4,028	47,535	11.80	19
20	Administrator	1,952	2,230	65,894	29.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,509	1,533	25,105	16.38	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	4,049	4,289	53,342	12.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,264	111,342	\$ 1,626,343 *	\$ 14.61	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	144	\$ 5,503	1.3	35
36	Medical Director	96	6,000	9.3	36
37	Medical Records Consultant	13	1,176	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	4,654	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	2,022	11.3	44
45	Social Service Consultant	24	2,022	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	361	\$ 21,377		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







**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 \$5,016
- (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? VAR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,201 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. N/A
- (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. \$ 143,230  
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. \$ NA 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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 51%  
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