FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0017590

Facility Name: BARRY COMMUNITY CARE 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: CAMILLE LOCKHART **Telephone Number:** (417) 865-8701
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 1/1/20 to 12/31/20 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) CHRISTINA 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: 1/1/20 Ending: 12/31/20

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	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,255	4,497	2,470	19,222	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,255	4,497	2,470	19,222	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.10%

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 [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 1,687

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	171,340	22,651	6,149	200,140		200,140		200,140			1
2	Food Purchase		118,772		118,772		118,772	(1,358)	117,414			2
3	Housekeeping	98,467	13,951		112,418		112,418		112,418			3
4	Laundry	59,933	8,661		68,594		68,594		68,594			4
5	Heat and Other Utilities			62,683	62,683		62,683		62,683			5
6	Maintenance	41,750	4,561	35,214	81,525		81,525	491	82,016			6
7	Other (specify):*							(1,936)	(1,936)			7
8	**TOTAL General Services**	371,490	168,596	104,046	644,132		644,132	(2,803)	641,329			8
	B. Health Care and Programs											
9	Medical Director			9,200	9,200		9,200		9,200			9
10	Nursing and Medical Records	1,367,230	95,727	16,090	1,479,047		1,479,047		1,479,047			10
10a	Therapy			302,504	302,504		302,504		302,504			10a
11	Activities	50,873	1,978	2,781	55,632		55,632		55,632			11
12	Social Services	32,885		1,486	34,371		34,371		34,371			12
13	CNA Training			18,768	18,768		18,768		18,768			13
14	Program Transportation											14
15	Other (specify):*							(68,741)	(68,741)			15
16	**TOTAL Health Care and Programs**	1,450,988	97,705	350,829	1,899,522		1,899,522	(68,741)	1,830,781			16
	C. General Administration											
17	Administrative	67,796			67,796		67,796	9,675	77,471			17
18	Directors Fees											18
19	Professional Services			212,688	212,688		212,688	1,547	214,235			19
20	Dues, Fees, Subscriptions & Promotions			19,655	19,655		19,655	(7,474)	12,181			20
21	Clerical & General Office Expenses	99,912	9,008	76,615	185,535		185,535	(4,010)	181,525			21
22	Employee Benefits & Payroll Taxes			269,294	269,294		269,294	5,731	275,025			22
23	Inservice Training & Education			5,620	5,620		5,620		5,620			23
24	Travel and Seminar			1,727	1,727		1,727	597	2,324			24
25	Other Admin. Staff Transportation							69	69			25
26	Insurance-Prop.Liab.Malpractice			24,920	24,920		24,920	42	24,962			26
27	Other (specify):*							(14,157)	(14,157)			27
28	**TOTAL General Administration**	167,708	9,008	610,519	787,235		787,235	(7,980)	779,255			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,990,186	275,309	1,065,394	3,330,889		3,330,889	(79,524)	3,251,365			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: 1/1/20 Ending: 12/31/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,568	26,568		26,568	544	27,112			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,296	9,296		9,296	36,584	45,880			32
33	Real Estate Taxes			59,575	59,575		59,575		59,575			33
34	Rent-Facility & Grounds			160,724	160,724		160,724	(155,002)	5,722			34
35	Rent-Equipment & Vehicles			6,700	6,700		6,700	504	7,204			35
36	Other (specify):*											36
37	**TOTAL Ownership**			262,863	262,863		262,863	(117,370)	145,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			80,162	80,162		80,162		80,162			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,444	148,444		148,444		148,444			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			228,606	228,606		228,606		228,606			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,990,186	275,309	1,556,863	3,822,358		3,822,358	(196,894)	3,625,464			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: 1/1/20 Ending: 12/31/20

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		2		4
5	Telephone, TV & Radio in Resident Rooms		21		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		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	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		21		18
19	Entertainment				19
20	Contributions		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	(7,516)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20,401)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(86,394)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,474)		$	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)	(82,420)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (82,420)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (196,894)		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.			$		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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	$ (365)	21	1
2	RESTAURANT/PUB REVENUE	(1,195)	2	2
3	COVID REIMB - GENERAL	(1,936)	7	3
4	COVID REIMB - HC	(68,741)	15	4
5	COVID REIMB - ADMIN	(14,157)	27	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**	(86,394)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,358)	0	0	0	0	0	0	0	0	0	0	(1,358)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	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	491	0	0	0	0	0	0	0	0	0	491	6
7	Other (specify):*	(1,936)	0	0	0	0	0	0	0	0	0	0	(1,936)	7
8	**TOTAL General Services**	(3,294)	491	0	0	0	0	0	0	0	0	0	(2,803)	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(68,741)	0	0	0	0	0	0	0	0	0	0	(68,741)	15
16	**TOTAL Health Care and Programs**	(68,741)	0	0	0	0	0	0	0	0	0	0	(68,741)	16
	C. General Administration													
17	Administrative	0	9,675	0	0	0	0	0	0	0	0	0	9,675	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,547	0	0	0	0	0	0	0	0	0	1,547	19
20	Fees, Subscriptions & Promotions	(7,516)	42	0	0	0	0	0	0	0	0	0	(7,474)	20
21	Clerical & General Office Expenses	(20,766)	16,756	0	0	0	0	0	0	0	0	0	(4,010)	21
22	Employee Benefits & Payroll Taxes	0	5,731	0	0	0	0	0	0	0	0	0	5,731	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	597	0	0	0	0	0	0	0	0	0	597	24
25	Other Admin. Staff Transportation	0	69	0	0	0	0	0	0	0	0	0	69	25
26	Insurance-Prop.Liab.Malpractice	0	42	0	0	0	0	0	0	0	0	0	42	26
27	Other (specify):*	(14,157)	0	0	0	0	0	0	0	0	0	0	(14,157)	27
28	**TOTAL General Administration**	(42,439)	34,459	0	0	0	0	0	0	0	0	0	(7,980)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,474)	34,950	0	0	0	0	0	0	0	0	0	(79,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	0	0	544	0	0	0	0	0	0	0	0	544	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	36,584	0	0	0	0	0	0	0	0	36,584	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,722	(160,724)	0	0	0	0	0	0	0	0	(155,002)	34
35	Rent-Equipment & Vehicles	0	504	0	0	0	0	0	0	0	0	0	504	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	6,226	(123,596)	0	0	0	0	0	0	0	0	(117,370)	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)**	(114,474)	41,176	(123,596)	0	0	0	0	0	0	0	0	(196,894)	45

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 RVOC LIVING TRUS	100	MONMOUTH NURSING HOME	MONMOUTH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		MAR-KA NURSING HOME	MASCOUTAH	CARE CENTERS		
				IMPEDIA	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	$	COMMUNITY CARE CENTERS, INC.	100.00%	$	$	1
2	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	5,722	5,722	2
3	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	504	504	3
4	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	9,675	9,675	4
5	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	16,756	16,756	5
6	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%			6
7	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	5,731	5,731	7
8	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,547	1,547	8
9	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	597	597	9
10	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	69	69	10
11	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	491	491	11
12	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	42	42	12
13	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	42	42	13
14	Total			$			$ 41,176	$ * 41,176	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: 1/1/20 Ending: 12/31/20

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%	$	$	15
16	V	5	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%			16
17	V								17
18	V	34	BUILDING RENT	160,724	BARRY HOLDING COMPANY LLC	100.00%		(160,724)	18
19	V	30	DEPRECIATION		BARRY HOLDING COMPANY LLC	100.00%	544	544	19
20	V	32	INTEREST EXPENSE		BARRY HOLDING COMPANY LLC	100.00%	36,584	36,584	20
21	V								21
22	V	26	LIABILITY INSURANCE	9,500	IMPEDIA	25.00%	9,500		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			$ 170,224			$ 46,628	$ * (123,596)	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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 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			$			$	$	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	Total			$			$ 0	$ *	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: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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	CHRISTINA GIARDINA	PRESIDENT			NONE	3	8.00	SALARY	$ 3,382	17.7	1
2	MARY SCAPER	SECRETARY			NONE	3	8.00	SALARY	2,897	17.7	2
3	JENNIFER GIARDINA				NONE			SALARY	1,698	17.7	3
4	MELISSA GIARDINA				NONE			SALARY	1,698	17.7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,675		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: 1/1/20 Ending: 12/31/20

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				$	$	5,178,602	$	1
2		ST GENEVIEVE CARE CTR						3,237,173		2
3		CCC OF LEMAY						3,311,617		3
4		SALEM CARE CENTER						2,609,086		4
5		MONMOUTH NH						2,925,440		5
6		MAR-KA NH						2,600,556		6
7		CCC OF SENECA						3,542,502		7
8		MT VERNON PLACE CARE						2,856,327		8
9		COUNTRY VIEW NH						2,779,629		9
10		MERAMEC NH						3,289,567		10
11		SEVILLE CARE CENTER						3,401,000		11
12		SALEM RES CARE						745,175		12
13		CARL JUNCTION RES CARE						662,641		13
14		MT VERNON RES CARE						521,652		14
15		SENECA HOME PLACE						504,128		15
16		HUDSON HOUSE						657,547		16
17		MAPLE GROVE LODGE						3,709,697		17
18		CCC OF AURORA						4,319,313		18
19		BARRY COMMUNITY CARE						3,699,929		19
20		LICKING RESIDENTIAL CTR						419,936		20
21		CCC OF GAINESVILLE						3,204,273		21
22		AL OF SILVER CREEK						932,273		22
23		MARK TWAIN MANOR						5,615,305		23
24		UNION CARE CENTER						3,689,859		24
25	TOTALS					$	$		$	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		COMMUNITY IN HOME				$	$	970,410	$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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 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						$	$		$	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: 1/1/20 Ending: 12/31/20

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	GREAT RIVERS BANK		X				$	$ 834,892	12/8/2028	4.2500	$ 36,584	1
2	CENTRAL BANK OF ST. LOUIS		X	PAYCHECK PROTECTION P	NO	4/20/20	406,422	406,422	4/20/2022	1.0000		2
3	MANAGED HEALTHCARE LLC		X	OMNICARE VENDOR SERVICES		12/3/19	70,973	29,489	12/1/2021	7.7500	9,160	3
4												4
5												5
	Working Capital											
6	MISC INT										136	6
7												7
8												8
9	TOTAL Facility Related						$ 477,395	$ 1,270,803			$ 45,880	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 477,395	$ 1,270,803			$ 45,880	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: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	34,957	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.)	$	59,575	2
3. Under or (over) accrual (line 2 minus line 1).	$	24,618	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,078	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.	$	59,696	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	59,974	8
	2016	60,941	9
	2017	60,127	10
	2018	59,807	11
	2019	59,575	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 Camille Lockhart

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 59,574.58	$ 59,574.58
2.		PT S SIDE NE	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,574.58	$ 59,574.58

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0017590

CONTACT PERSON REGARDING THIS REPORT Camille Lockhart

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	#VALUE!		$ 20,739	3

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		1975	1975	$ 805,055	$	30	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO			1976	936		20			936	9
10	DRIVE			1987	3,002		31			3,001	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	116	15	116		1,931	30
31	LANDSCAPING (REMOVED CAP DESK AUDIT 2008)			2006							31
32	CONCRETE WORK			2006	4,625	308	15	308		4,340	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 # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	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		10			7,825	41
42	FLOORING	2010	1,325	13	10	13		1,325	42
43	8 REPLACEMENT WINDOWS	2010	1,265	107	10	107		1,265	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		LEASE LIFE			14,700	53
54	FIREWALL MODIFICATIONS	2015	5,601		LEASE LIFE			5,601	54
55	PVC LINE UNDER PARKING LOT	2018	2,040	480	LEASE LIFE	480		1,360	55
56	ROOFTOP: REMOVE & REPLACE HVAC	2019	17,112	2,445	7	2,445		3,056	56
57	WATER HEATER 85 GALLON	2020	6,445	77	7	77		77	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)		$ 1,080,719	$ 3,546		$ 3,546	$	$ 254,274	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: 1/1/20 Ending: 12/31/20

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	$ 335,217	$ 5,623	$ 5,623	$		$ 314,447	71
72	Current Year Purchases	23,859	4,731	4,731			4,731	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 359,076	$ 10,354	$ 10,354	$		$ 319,178	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	2017 DODGE GRAND CARA	2017	2018	$ 52,850	$ 13,213	$ 13,213	$	4	$ 27,527	76
77	2011 CHAMP 15-PAS BUS	2011	2011	51,580				4	51,580	77
78										78
79										79
80	TOTALS			$ 104,430	$ 13,213	$ 13,213	$		$ 79,107	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)	$ 1,564,964	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,113	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,113	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)	$ 652,559	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: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 6,700 Description: COPIER $5,140; ICE MACHINE $1,560
(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: 1/1/20 Ending: 12/31/20

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.

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	$	1,440	$ 95,964	$	1,440	$ 95,964	1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		1,051	90,509		1,051	90,509	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.a2&3	hrs		2,147	116,031		2,147	116,031	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				68,592		68,592	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB & XRAY	39.3					10,522		10,522	12
13	Other (specify): AMBULANCE						1,048		1,048	13
14	TOTAL			$	4,638	$ 302,504	$ 80,162	4,638	$ 382,666	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.

STATE OF ILLINOIS

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 326,655	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	578,189		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,000		5
6	Prepaid Insurance	2,122		6
7	Other Prepaid Expenses	14,244		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 922,210	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,814		14
15	Leasehold Improvements, at Historical Cost	57,690		15
16	Equipment, at Historical Cost	487,064		16
17	Accumulated Depreciation (book methods)	(461,106)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	53,884		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 88,462	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,010,672	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 377,705	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,864		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,431		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,429		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,078		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 BARRY HOLD/ACC MGT FEE	949,751		36
37		162,197		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,717,455	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	435,911		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		502,271		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 938,182	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,655,637	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,644,965)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,010,672	$	48

***(See instructions.)**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,972,909)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,972,909)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,282	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	465,384	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) PPA - BAD DEBT ALLOWANCE ADJUSTM	(179,200)	15
16	Other (describe) PRIOR PERIOD ADJUSTMENTS	(17,522)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 327,944	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)**	$ (1,644,965)	24 *

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

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 3,435,214	1
2	Discounts and Allowances for all Levels	(1,345,229)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,089,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,556,858	6
7	Oxygen	131,335	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,688,193	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	1,195	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)**	$ 1,195	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	**COVID PROVIDER RELIEF FUNDS**	102,267	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,881,640	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	644,132	31
32	Health Care	1,899,522	32
33	General Administration	787,235	33
	B. Capital Expense		
34	Ownership	262,863	34
	C. Ancillary Expense		
35	Special Cost Centers	80,162	35
36	Provider Participation Fee	148,444	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,822,358	40
41	**Income before Income Taxes (line 30 minus line 40)****	59,282	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 59,282	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,600,811	44
45	Private Pay - Net Inpatient Revenue	1,012,043	45
46	Medicare - Net Inpatient Revenue	340,129	46
47	Other-(specify) **HOSPICE**	75,235	47
48	Other-(specify) **BAD DEBT/PRIOR PERIOD/CONT ADJ/PT B**	(938,233)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,089,985	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not completed 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: 1/1/20 Ending: 12/31/20

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	1,931	2,049	$ 71,651	$ 34.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,745	11,255	326,607	29.02	3
4	Licensed Practical Nurses	12,175	13,049	301,029	23.07	4
5	CNAs & Orderlies	38,874	41,403	629,123	15.20	5
6	CNA Trainees	2,220	2,241	25,114	11.21	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,979	2,154	37,190	17.27	9
10	Activity Assistants	633	983	13,683	13.92	10
11	Social Service Workers	1,976	2,081	32,885	15.80	11
12	Dietician					12
13	Food Service Supervisor	3,689	4,048	54,837	13.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,377	10,904	116,503	10.68	15
16	Dishwashers					16
17	Maintenance Workers	2,016	2,142	41,750	19.49	17
18	Housekeepers	7,473	7,964	98,467	12.36	18
19	Laundry	4,508	5,106	59,933	11.74	19
20	Administrator	1,939	2,067	67,796	32.80	20
21	Assistant Administrator					21
22	Other Administrative	2,887	2,998	42,621	14.22	22
23	Office Manager	2,291	2,492	57,291	22.99	23
24	Clerical					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	1,019	1,152	13,706	11.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,732	114,088	$ 1,990,186 *	$ 17.44	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	526	$ 6,316	1.3	35
36	Medical Director	767	9,200	9.3	36
37	Medical Records Consultant	189	2,270	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	548	6,579	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	165	1,981	11.3	44
45	Social Service Consultant	124	1,486	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,319	$ 27,832		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	43	3,027	10.3	51
52	Certified Nurse Assistants/Aides	64	1,001	10.3	52
53	TOTAL (lines 50 - 52)	107	$ 4,028		53

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARCI GEIST	ADMINISTATOR		$ 67,796
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,796

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
WALNUT CREEK	MGMT FEES	$ 182,868
CT CORPORATION	LEGAL	476
ROSENBLUM GOLDENHERSH	LEGAL	282
SCHINDLER LAW FIRM PC	LEGAL	10,146
DANIEL MAHER	LEGAL	180
BKD, LLP	ACCOUNTING	15,239
	PROF FEES	3,497
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 212,688

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,681
Unemployment Compensation Insurance	
FICA Taxes	157,177
Employee Health Insurance	9,725
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	4,545
401K CONTRIBUTION	
OSHA EMPLOYEES BENEFITS	
EMPLOYEE COVID LAB TESTING EXP	29,166
HOME OFFICE ALLOCATION	5,731
TOTAL (agree to Schedule V, line 22, col.8)	$ 275,025

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,656
Health Care Worker Background Check	
(Indicate # of checks performed 16)	640
Patient Background Checks	
DUES & SUBSCRIPTIONS	5,721
TAXES & LICENSES	2,122
ADVERTISING-YELLOW PGS &OTHER	7,516
HOME OFFICE ALLOCATION	42
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(7,516)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,181

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 330
In-State Travel	1,397
Seminar Expense	
HOME OFFICE ALLOCATION	597
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,324

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 $5,472**

(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. $ **19,453** 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. $ **148,444**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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