FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0040345

Facility Name: Joshua Manor

Address: 100 West Locust St (Number) Hoyleton (City) 62803 (Zip Code)

County: Washington

Telephone Number: (618) 493-6071 **Fax #** (618) 493-6145

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1993

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
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 7/1/2013 to 6/30/2014 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) Jessica Rosales
(Title) Chief Operating Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	3,859			3,859	13
14	TOTALS	3,859			3,859	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.08%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/30/1993 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	9,755	2,477	1,076	13,308		13,308		13,308			1
2	Food Purchase		21,754		21,754		21,754		21,754			2
3	Housekeeping		2,622		2,622		2,622		2,622			3
4	Laundry		3,471		3,471		3,471		3,471			4
5	Heat and Other Utilities			14,838	14,838		14,838		14,838			5
6	Maintenance	12,605	3,639	5,131	21,375		21,375		21,375			6
7	Other (specify):*											7
8	TOTAL General Services	22,360	33,963	21,045	77,368		77,368		77,368			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	208,345	8,324	1,850	218,519		218,519		218,519			10
10a	Therapy			761	761		761		761			10a
11	Activities		1,746		1,746		1,746		1,746			11
12	Social Services			1,152	1,152		1,152		1,152			12
13	CNA Training											13
14	Program Transportation			3,883	3,883		3,883		3,883			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	208,345	10,070	7,646	226,061		226,061		226,061			16
	C. General Administration											
17	Administrative	17,628		84,531	102,159		102,159	(84,531)	17,628			17
18	Directors Fees							2,274	2,274			18
19	Professional Services			1,348	1,348		1,348	12,066	13,414			19
20	Dues, Fees, Subscriptions & Promotions			1,307	1,307		1,307	3,214	4,521			20
21	Clerical & General Office Expenses	704	3,206	8,547	12,457		12,457	42,417	54,874			21
22	Employee Benefits & Payroll Taxes			68,910	68,910		68,910	5,589	74,499			22
23	Inservice Training & Education			141	141		141		141			23
24	Travel and Seminar			1,792	1,792		1,792	1,453	3,245			24
25	Other Admin. Staff Transportation			2,796	2,796		2,796	400	3,196			25
26	Insurance-Prop.Liab.Malpractice			5,908	5,908		5,908	82	5,990			26
27	Other (specify):*											27
28	TOTAL General Administration	18,332	3,206	175,280	196,818		196,818	(17,036)	179,782			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	249,037	47,239	203,971	500,247		500,247	(17,036)	483,211			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 Joshua Manor #0040345 **Report Period Beginning:** 7/1/2013 **Ending:** 6/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,167	17,167		17,167	1,174	18,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,556	30,556		30,556	8,734	39,290			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,933	4,933			34
35	Rent-Equipment & Vehicles							1,194	1,194			35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,723	47,723		47,723	16,035	63,758			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,913		1,913		1,913		1,913			39
40	Barber and Beauty Shops			50	50		50		50			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,823	33,823		33,823		33,823			42
43	Other (specify):* Non-allowable Costs											43
44	**TOTAL Special Cost Centers**		1,913	33,873	35,786		35,786		35,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	249,037	49,152	285,567	583,756		583,756	(1,001)	582,755			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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(733)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(268)	43		19
20	Contributions				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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(13)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,014)		$	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)	13		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 13		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,001)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Joshua Manor

ID# 0040345

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income against Office Supplies	$ (13)	21	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Joshua Manor # 0040345 **Report Period Beginning:** 7/1/2013 **Ending:** 6/30/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(84,531)	0	0	0	0	0	0	0	0	0	(84,531)	17
18	Directors Fees	0	2,274	0	0	0	0	0	0	0	0	0	2,274	18
19	Professional Services	0	12,066	0	0	0	0	0	0	0	0	0	12,066	19
20	Fees, Subscriptions & Promotions	0	3,214	0	0	0	0	0	0	0	0	0	3,214	20
21	Clerical & General Office Expenses	(13)	42,430	0	0	0	0	0	0	0	0	0	42,417	21
22	Employee Benefits & Payroll Taxes	0	5,589	0	0	0	0	0	0	0	0	0	5,589	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,453	0	0	0	0	0	0	0	0	0	1,453	24
25	Other Admin. Staff Transportation	0	400	0	0	0	0	0	0	0	0	0	400	25
26	Insurance-Prop.Liab.Malpractice	0	82	0	0	0	0	0	0	0	0	0	82	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13)	(17,023)	0	0	0	0	0	0	0	0	0	(17,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13)	(17,023)	0	0	0	0	0	0	0	0	0	(17,036)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Joshua Manor # 0040345 **Report Period Beginning:** 7/1/2013 **Ending:** 6/30/2014

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	1,174	0	0	0	0	0	0	0	0	0	1,174	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,734	0	0	0	0	0	0	0	0	8,734	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,933	0	0	0	0	0	0	0	0	4,933	34
35	Rent-Equipment & Vehicles	0	0	1,194	0	0	0	0	0	0	0	0	1,194	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	1,174	14,861	0	0	0	0	0	0	0	0	16,035	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):*	(1,001)	0	1,001	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,001)	0	1,001	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,014)	(15,849)	15,862	0	0	0	0	0	0	0	0	(1,001)	45

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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	17	Administrative	$ 84,531	Progressive Housing, Inc.	100.00%	$	$ (84,531)	1
2	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,274	2,274	2
3	V	19	Professional Services		Progressive Housing, Inc.	100.00%	12,066	12,066	3
4	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,214	3,214	4
5	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	42,430	42,430	5
6	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	5,589	5,589	6
7	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,453	1,453	7
8	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	400	400	8
9	V	26	Insurance		Progressive Housing, Inc.	100.00%	82	82	9
10	V	30	Depreciation		Progressive Housing, Inc.	100.00%	1,174	1,174	10
11	V								11
12	V								12
13	V								13
14	Total			$ 84,531			$ 68,682	$ * (15,849)	14

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	32	Interest	$	Progressive Housing, Inc.	100.00%	$ 8,734	$ 8,734	15
16	V	34	Rent		Progressive Housing, Inc.	100.00%	4,933	4,933	16
17	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	1,194	1,194	17
18	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,001	1,001	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			$			$ 15,862	$ * 15,862	39

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates	Hoyleton	Perfection			7
8			Park Place	Pana	Cleaning	Olympia Fields	Housekeeping	8
9			Cardinal	Woodlawn				9
10			Western Gardens	MT. Vernon				10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	Edward Childers	Chairman	Board Member	None	9,218	3Hrs/MTG	1.00	Dir. Fees	$ 382	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,450	3Hrs/MTG	1.00	Dir. Fees	350	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,193	3Hrs/MTG	1.00	Dir. Fees	407	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,112	3Hrs/MTG	1.00	Dir. Fees	488	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,226	3Hrs/MTG	1.00	Dir. Fees	374	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,215	3Hrs/MTG	1.00	Dir. Fees	385	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	157,170	1.18	2.95	Salary	4,851	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,237		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

Joshua Manor
0040345
6/30/2014
SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Edward Childers	Cora Flota	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Misc Exp	Total	Larry Manson
Sparta Terrace	381	372	384	348	380	386	11	2,262	4,928
Ellner Terrace	469	459	473	429	468	476	17	2,791	5,777
Taylorville Terrace	479	469	483	438	478	487	17	2,851	7,907
Aviston Terrace	413	404	417	378	412	419	13	2,456	7,111
Briarbrook Place	481	471	486	440	481	488	16	2,863	7,047
Harris Place	444	434	448	406	443	451	15	2,641	6,894
Joshua Manor	382	374	385	350	407	388	(12)	2,274	4,851
Terra Estates	454	444	457	415	453	460	15	2,698	6,695
Park Place	449	439	452	410	448	455	15	2,668	6,703
Western Gardens	229	234	230	211	228	229	64	1,424	3,739
Galaxy	269	273	268	247	268	276	60	1,662	5,086
Cardinal	195	202	198	180	195	199	57	1,226	3,839
Bill Goat Hill	244	249	242	224	243	243	68	1,513	4,588
Country Club Hill	207	213	210	191	207	211	58	1,298	4,039
Lee Street	259	263	257	238	258	253	74	1,602	4,638
Baker Street	197	203	195	182	197	196	67	1,236	3,849
182nd Street	222	228	220	205	221	225	64	1,384	4,178
Osage	183	190	181	169	183	184	64	1,154	3,616
Oakwood	214	220	212	197	213	222	58	1,337	3,879
Blair	296	300	295	272	306	286	71	1,827	4,760
Lowell	260	264	258	239	259	260	69	1,609	4,831
Marquette	242	247	240	223	241	245	65	1,503	4,644
Cherry	229	234	227	211	228	235	61	1,426	4,266
Luella	222	228	219	205	221	228	60	1,383	5,231
Olivia	307	311	305	282	306	282	96	1,889	3,161
Huron	223	229	226	206	222	234	50	1,390	4,146
Wilshire	262	267	266	241	262	258	69	1,625	4,926
Constance	223	228	226	205	222	231	55	1,390	1,550
175th Place	265	270	264	244	265	263	71	1,643	5,015

Sauganash							0	0		4,256
Steger	514	502	502	464	502	464	109	3,055		8,939
Waltonville	186	182	187	166	185	171	31	1,108		3,402
Mt. Vernon	200	197	187	184	198	195	33	1,193		3,530
Total PHI	9,600	9,600	9,600	8,800	9,600	9,600	1,581	58,381	58,381	162,021

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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: Progressive Housing, Inc.
Street Address: 3615 Park Drive, Suite 100
City / State / Zip Code: Olympia Fields, IL 60461
Phone Number: (708) 283-1530
Fax Number: (708) 283-2470

	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	18	Director Fees	Budgeted Rev/Dir Cost	13,171,654	33	58,381		394,378	$ 2,274	1
2	19	Professional Services	Budgeted Rev/Dir Cost	13,171,654	33	207,339		394,378	12,066	2
3	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	13,171,654	33	85,685		394,378	3,214	3
4	21	Clerical and General Office	Budgeted Rev/Dir Cost	13,171,654	33	1,086,305	1,000,711	394,378	42,430	4
5	22	Employee Benefits	Budgeted Rev/Dir Cost	13,171,654	33	158,964		394,378	5,589	5
6	24	Travel and Seminar	Budgeted Rev/Dir Cost	13,171,654	33	44,262		394,378	1,453	6
7	25	Auto Expense	Budgeted Rev/Dir Cost	13,171,654	33	9,781		394,378	400	7
8	26	Insurance	Budgeted Rev/Dir Cost	13,171,654	33	2,769		394,378	82	8
9	30	Depreciation	Budgeted Rev/Dir Cost	13,171,654	33	30,745		394,378	1,174	9
10	32	Interest	Budgeted Rev/Dir Cost	13,171,654	33	234,828		394,378	8,734	10
11	34	Rent	Budgeted Rev/Dir Cost	13,171,654	33	117,060		394,378	4,933	11
12	35	Equipment Rental	Budgeted Rev/Dir Cost	13,171,654	33	39,570		394,378	1,194	12
13	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	13,171,654	33	(6,363)		394,378	1,001	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					$ 2,069,326	$ 1,000,711		$ 84,544	25

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 793,404	$ 567,457	08/15/26	6.7500	$ 29,534	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,022	6
7	Allocation from Home Office-Interest										9,420	7
8	Allocation from Home Office-Amortization										472	8
9	TOTAL Facility Related						$ 793,404	$ 567,457			$ 40,448	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(1,158)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,158)	14
15	TOTALS (line 9+line14)						$ 793,404	$ 567,457			$ 39,290	15

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

*** 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 Joshua Manor **#** 0040345 **Report Period Beginning:** 7/1/2013 **Ending:** 6/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Joshua Manor COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040345

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,726 B. General Construction Type: Exterior Brick/Shingle Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (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? [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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	46,100	1993	$ 20,000	1
2	Allocated from Home Office			94	2
3	TOTALS	46,100		$ 20,094	3

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	16		1993	1990	$ 406,000	$ 10,150	40	$ 10,150	$	$ 214,887	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements - Smoke Detectors, & Pull Station			1994	1,590		15			1,590	9
10	Deluxe Barn			1994	1,684		15			1,684	10
11	Carpet			1997	1,055	35	15	35		1,054	11
12	Tile			1999	849	57	15	57		823	12
13	Shower			1999	2,789	186	15	186		2,696	13
14	Tile			2004	997	66	15	66		635	14
15	Bathroom Tile			2006	420	28	15	28		233	15
16	Kitchen Remodel			2006	1,239	83	15	83		635	16
17	Kitchen Remodel			2006	1,287	86	15	86		651	17
18	Kitchen Remodel			2006	1,955	130	15	130		987	18
19	Bedroom Remodel			2007	10,192	680	15	680		5,060	19
20	Bathroom Remodel			2007	695	46	15	46		314	20
21	Gazebo			2007	1,796	120	15	120		789	21
22	Roof Repair			2008	15,757	1,051	15	1,051		6,427	22
23	Roof Repair			2008	335	22	15	22		133	23
24	Flooring			2008	225	15	15	15		90	24
25	Garage Repair			2008	529	35	15	35		202	25
26	Building Improvements - Painting			2010	717	48	15	48		212	26
27	Living Room Flooring			2010	1,252	83	15	83		353	27
28	Living Room and Laundry Flooring			2010	797	53	15	53		225	28
29	Living Room and Bathroom Flooring Tile			2010	813	54	15	54		225	29
30	Install 5 ton condensing unit			2010	2,800	187	15	187		748	30
31	New Furnace			2012	2,100	140	15	140		327	31
32	New A/C Condesner and Coil			2012	3,600	240	15	240		500	32
33	New Sprinkler Heads			2012	1,420	95	15	95		190	33
34	Gutters and Extensions			2013	1,675	102	15	102		102	34
35	New Furnace			2013	2,275	114	15	114		114	35
36	Allocation from Home Office				1,949			83	83	367	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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 468,792	$ 13,906		$ 13,989	$ 83	$ 242,253	70

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$ 28,020	$ 2,932	$ 2,932	$	5-10Yrs	$ 18,976	71
72	Current Year Purchases	2,271	166	166		5-10Yrs	166	72
73	Fully Depreciated Assets	17,192				5-10Yrs	17,192	73
74	Allocated from Home Office	8,246		904	904		6,398	74
75	TOTALS	$ 55,729	$ 3,098	$ 4,002	$ 904		$ 42,732	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	Resident Transportation	94 Ford Van	2008	$ 2,100	$	$	$	5	$ 2,100	76
77	Facility Use	2005 Ford Taurus SE	2005	17,283				5	17,283	77
78	Facility Use	Capitalized Repairs	2013	814	163	163		5	326	78
79	Allocated from Home Office			4,468		187	187		3,645	79
80	TOTALS			$ 24,665	$ 163	$ 350	$ 187		$ 23,354	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)	$ 569,280	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,167	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,341	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,174	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 308,339	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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		Allocated from Home Office			4,933			6
7	TOTAL				$ 4,933 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 1,194 Description: Allocated from Home Office - postage machine, copier, storage
    (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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

It is the policy of this facility to only hire certified nurses aides.

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,913		1,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$ 1,913		$ 1,913	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 Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2014 (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	$ 55,128	$ 55,128	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,992)	29,547	29,547	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,812	3,812	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves/Deposits	57,293	57,293	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 145,780	$ 145,780	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,094	13
14	Buildings, at Historical Cost	466,843	468,792	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	67,680	80,394	16
17	Accumulated Depreciation (book methods)	(296,811)	(308,339)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Loan Costs	4,623	4,623	22
23	Other(specify): Deposits	684	684	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 263,019	$ 266,248	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 408,799	$ 412,028	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,425	$ 8,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,193	11,193	30
31	Accrued Taxes Payable (excluding real estate taxes)	953	953	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,526	8,526	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	3,691	3,691	36
37	Deposits/Deferred Income	910	910	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 33,698	$ 33,698	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	567,457	567,457	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 567,457	$ 567,457	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 601,155	$ 601,155	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (192,356)	$ (189,127)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 408,799	$ 412,028	48

*(See instructions.)

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (186,568)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (186,568)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(118,647)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (118,647)	17
	B. Transfers (Itemize):		
18	**Allocation of Progressive Housing, Inc. Balance Sheet**	112,859	18
19	**to individual facilities**		19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 112,859	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (192,356)	24 *

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	$ 464,863	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 464,863	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	198	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198	23
	D. Non-Operating Revenue		
24	Contributions	48	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 465,109	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	77,368	31
32	Health Care	226,061	32
33	General Administration	196,818	33
	B. Capital Expense		
34	Ownership	47,723	34
	C. Ancillary Expense		
35	Special Cost Centers	1,963	35
36	Provider Participation Fee	33,823	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 583,756	40
41	**Income before Income Taxes (line 30 minus line 40)****	(118,647)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (118,647)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 464,863	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 464,863	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Joshua Manor
ID# 0040345
FYE 6/30/2014

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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
2	Assistant Director of Nursing					2
3	Registered Nurses	495	513	11,101	21.64	3
4	Licensed Practical Nurses	1,114	1,163	17,969	15.45	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,082	1,082	9,755	9.02	15
16	Dishwashers					16
17	Maintenance Workers	885	926	12,605	13.61	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	604	653	17,628	27.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	64	67	704	10.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,686	2,758	39,397	14.28	29
30	Habilitation Aides (DD Homes)	15,295	15,634	139,878	8.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,225	22,796	$ 249,037 *	$ 10.92	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	20	$ 1,076	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	817	L10, C3	39
40	Physical Therapy Consultant	15	326	L10a, C3	40
41	Occupational Therapy Consultant	20	435	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	21	1,152	L12, C3	45
46	Other(specify) Dental	9	470	L10, C3	46
47	Psychological Consultant	3	563	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	88	$ 4,839		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Missy Reed	Administrator	0	$ 12,883
John Mirecki	Administrator	0	4,100
Christina Durbin	Administrator	0	645
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 17,628

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 84,531
TOTAL (agree to Schedule V, line 17, col. 3)	$ 84,531
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakly Payroll Service	Payroll Service	$ 1,348
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,348

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,256
Unemployment Compensation Insurance	17,590
FICA Taxes	18,751
Employee Health Insurance	11,923
Employee Meals	4,299
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	91
Other Employee Benefits	
Allocated from Home Office	5,589
TOTAL (agree to Schedule V, line 22, col.8)	$ 74,499

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 8)	80
Patient Background Checks	
Hiring Expense	992
Miscellaneous Dues & Fees	235
Allocated from Home Office	3,214
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,521

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	775
Seminar Expense	1,017
Allocated from Home Office	1,453
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,245

**See instructions.

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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

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

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **N/A** 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? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,250** Line **10**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **33,823**
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? **Yes**

(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. $ **4,299** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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? **55**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **Yes**
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? **Yes**
Firm Name: **Heinold-Banwart, LTD**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.