



Facility Name & ID Number Joshua Manor

# 0040345 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	5,856	6
7	16	TOTALS	16	5,856	7

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

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,112			5,112	13
14	TOTALS	5,112			5,112	14

**C. Percent Occupancy.** (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.30%

**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  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

**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  Date 04/30/1993 NO

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	20,771	1,504	1,485	23,760		23,760		23,760		1
2	Food Purchase		27,507		27,507		27,507		27,507		2
3	Housekeeping		3,370		3,370		3,370	13	3,383		3
4	Laundry		1,441		1,441		1,441		1,441		4
5	Heat and Other Utilities			12,805	12,805		12,805		12,805		5
6	Maintenance	11,847	3,530	3,965	19,342		19,342	905	20,247		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>32,618</b>	<b>37,352</b>	<b>18,255</b>	<b>88,225</b>		<b>88,225</b>	<b>918</b>	<b>89,143</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			950	950		950		950		9
10	Nursing and Medical Records	244,914	8,462	304	253,680		253,680		253,680		10
10a	Therapy										10a
11	Activities		234	43	277		277		277		11
12	Social Services			1,260	1,260		1,260		1,260		12
13	CNA Training										13
14	Program Transportation			7,230	7,230		7,230		7,230		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>244,914</b>	<b>8,696</b>	<b>9,787</b>	<b>263,397</b>		<b>263,397</b>		<b>263,397</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	37,142		109,049	146,191		146,191	(109,049)	37,142		17
18	Directors Fees							4,375	4,375		18
19	Professional Services			8,504	8,504		8,504	6,892	15,396		19
20	Dues, Fees, Subscriptions & Promotions			1,284	1,284		1,284	2,500	3,784		20
21	Clerical & General Office Expenses	8,429	2,441	9,330	20,200		20,200	71,949	92,149		21
22	Employee Benefits & Payroll Taxes			104,790	104,790		104,790	11,424	116,214		22
23	Inservice Training & Education			1,927	1,927		1,927		1,927		23
24	Travel and Seminar			993	993		993	2,213	3,206		24
25	Other Admin. Staff Transportation			4,385	4,385		4,385	1,150	5,535		25
26	Insurance-Prop.Liab.Malpractice			9,377	9,377		9,377	464	9,841		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>45,571</b>	<b>2,441</b>	<b>249,639</b>	<b>297,651</b>		<b>297,651</b>	<b>(8,082)</b>	<b>289,569</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>323,103</b>	<b>48,489</b>	<b>277,681</b>	<b>649,273</b>		<b>649,273</b>	<b>(7,164)</b>	<b>642,109</b>		<b>29</b>

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name &amp; ID Number

Joshua Manor

#0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			3,558	3,558		3,558	16,823	20,381			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			466	466		466	(466)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,212	2,212			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			4,024	4,024		4,024	18,569	22,593			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,911		1,911		1,911		1,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,630	38,630		38,630		38,630			42
43	Other (specify):* <b>Disallowed Costs</b>											43
44	<b>TOTAL Special Cost Centers</b>		1,911	38,630	40,541		40,541		40,541			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	323,103	50,400	320,335	693,838		693,838	11,405	705,243			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Joshua Manor**

# **0040345**

Report Period Beginning:

**7/1/2019**

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**6/30/2020**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	14,559	30		9
10	Interest and Other Investment Income	(466)	32		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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(46)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28)	19		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	(2,614)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 11,405		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 11,405		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

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

SEE ACCOUNTANTS' PREPARATION REPORT

Joshua Manor

ID# 0040345

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (2,367)	43	1
2	Expense Fixed Asset Additions under \$2,500	699	6	2
3	Miscellaneous Income Offset	(5)	21	3
4	Rental Income Offset	(941)	34	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
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28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(2,614)		49

**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
<u>Progressive Housing, Inc</u>	<u>100</u>	<u>See Pg 6-Supp</u>		<u>See Pg 6-Supp</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>3 Housekeeping</u>	\$	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	\$ <u>13</u>	\$	<u>13</u>   1
2	V	<u>6 Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>206</u>		<u>206</u>   2
3	V	<u>18 Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>4,375</u>		<u>4,375</u>   3
4	V	<u>19 Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>6,920</u>		<u>6,920</u>   4
5	V	<u>20 Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,546</u>		<u>2,546</u>   5
6	V	<u>21 Clerical and General Office</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>71,954</u>		<u>71,954</u>   6
7	V	<u>22 Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>11,424</u>		<u>11,424</u>   7
8	V	<u>24 Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,213</u>		<u>2,213</u>   8
9	V	<u>25 Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,150</u>		<u>1,150</u>   9
10	V	<u>26 Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>464</u>		<u>464</u>   10
11	V	<u>30 Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,264</u>		<u>2,264</u>   11
12	V	<u>34 Rent</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>941</u>		<u>941</u>   12
13	V	<u>35 Equipment Rental</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,212</u>		<u>2,212</u>   13
14	Total		\$			\$ <u>106,682</u>	\$ *	<u>106,682</u>   14

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

SEE ACCOUNTANTS' PREPARATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	\$ 2,367	\$ 2,367
16	V	17 Administrative	109,049	Progressive Housing, Inc.	100.00%		(109,049)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 109,049			\$ 2,367	\$ * (106,682)

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Joshua Manor

# 0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

## 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 -closed	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Flossmoor	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Aviston Terrace	Aviston	& Housing	Waltonville	Workshop-closed	6
7			Park Place	Pana	Progressive Careers			7
8			Cardinal	Woodlawn	& Housing	Mt Vernon	Workshop-closed	8
9			Western Gardens	MT. Vernon	Perfection			9
10			Galaxy	Woodlawn	Cleaning	Olympia Fields	Housekeeping	10
11			Bill Goat Hill	MT. Vernon				11
12			Country Club Hill	Country Club Hills				12
13			Lee street	Country Club Hills				13
14			Baker Street	Country Club Hills				14
15			182nd Street	Country Club Hills				15
16			Osage	Park Forest				16
17			Oakwood	Park Forest				17
18			Blair	Park Forest				18
19			Lowell	Hazelcrest				19
20			Marquette	Park Forest				20
21			Cherry	Park Forest				21
22			Luella	Sauk Village				22
23			Olivia	Sauk Village				23
24			Huron	Park Forest				24
25			Wilshire	Park Forest				25
26			Constance - closed	Sauk Village				26
27			175th Place	Country Club Hills				27
28			Sauganash	Park Forest				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number

Joshua Manor

# 0040345

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	8,230	3Hrs/MTG	1.00	Dir. Fees	\$ 570	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,229	3Hrs/MTG	1.00	Dir. Fees	571	L18,C8	3
4	Hal Brown	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	6
7	Eileen Mullin	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	7
8	Julie Lilie	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	8
9	Shawn Jeffers	Director-Partial yr	Board Member	None	1,496	3Hrs/MTG	1.00	Dir. Fees	104	L18,C8	9
10											10
11					Misc Expenses				20		11
12											12
13								TOTAL	\$ 4,375		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor

# 0040345

Report Period Beginning:

7/1/2019

Ending: 5/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Progressive Housing, Inc.

Street Address

20180 Governors Dr., Suite 300

City / State / Zip Code

Olympia Fields, IL 60461

Phone Number

( 708) 283-1530

Fax Number

( 708) 283-2470

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Bed Capacity/Specific Alloc.	252	28	\$ 523	16	\$ 13	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	252	28	4,326	16	206	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	252	28	67,510	16	4,375	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	252	28	109,179	16	6,920	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	252	28	42,077	16	2,546	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	252	28	1,118,951	935,187	71,954	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	252	28	195,610	16	11,424	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	252	28	33,408	16	2,213	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	252	28	18,416	16	1,150	9
10	26	Insurance	Bed Capacity/Specific Alloc.	252	28	7,288	16	464	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	252	28	34,937	16	2,264	11
12	34	Rent	Bed Capacity/Specific Alloc.	252	28	14,823	16	941	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	252	28	45,991	16	2,212	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	252	28	43,564	16	2,367	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,736,603	\$ 935,187	\$ 109,049	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Joshua Manor

# 0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Enterprise	X	Vehicle	\$672.44	3/2020	34,173	32,732	3/2025	0.0588	466										
7	Peoples Bank	X	PPP Loan		4/14/20	116,788	116,788													
8																				
9	<b>TOTAL Facility Related</b>			\$672.44		\$ 150,961	\$ 149,520			\$ 466										
<b>B. Non-Facility Related*</b>																				
10																				
11								Interest Income Offset		(466)										
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (466)										
15	<b>TOTALS (line 9+line14)</b>					\$ 150,961	\$ 149,520			\$										

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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2019 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 2020 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	N/A	8
	2016	N/A	9
	2017	N/A	10
	2018	N/A	11
	2019	N/A	12

N/A - Not for profit entity

**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.**

SEE ACCOUNTANTS' PREPARATION REPORT

## 2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Joshua Manor COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040345

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

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

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach 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.**

Facility Name & ID Number Joshua Manor

# 0040345 Report Period Beginning:

7/1/2019 Ending:

6/30/2020

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Rows include Facility (46,100 sq ft, 1993, \$20,000), Allocated from Home Office (7,369), and TOTALS (46,100, \$27,369).

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Joshua Manor

# 0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1993	1990	\$ 406,000 *	\$	40	\$ 10,150	\$ 10,150	\$ 275,787	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
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		15			1,055	11
12	Tile		1999	849		15			849	12
13	Shower		1999	2,789		15			2,789	13
14	Tile		2004	997		15	32	32	997	14
15	Bathroom Tile		2006	420		15	28	28	401	15
16	Kitchen Remodel		2006	1,239		15	83	83	1,133	16
17	Kitchen Remodel		2006	1,287		15	86	86	1,167	17
18	Kitchen Remodel		2006	1,955		15	130	130	1,767	18
19	Bedroom Remodel		2007	10,192		15	680	680	9,140	19
20	Bathroom Remodel		2007	695		15	46	46	590	20
21	Gazebo		2007	1,796		15	120	120	1,509	21
22	Roof Repair		2008	15,757		15	1,050	1,050	12,729	22
23	Roof Repair		2008	335		15	22	22	265	23
24	Flooring		2008	225		15	15	15	180	24
25	Garage Repair		2008	529		15	35	35	412	25
26	Building Improvements - Painting		2010	717		15	48	48	500	26
27	Living Room Flooring		2010	1,252		15	83	83	851	27
28	Living Room and Laundry Flooring		2010	797		15	53	53	543	28
29	Living Room and Bathroom Flooring Tile		2010	813		15	54	54	549	29
30	Install 5 ton condensing unit		2010	2,800		15	187	187	1,870	30
31	New Furnace		2012	2,100		15	140	140	1,167	31
32	New A/C Condesner and Coil		2012	3,600		15	240	240	1,940	32
33	New Sprinkler Heads		2012	1,420		15	95	95	676	33
34	Gutters and Extensions		2013	1,675		15	112	112	774	34
35	New Furnace		2013	2,275		15	152	152	1,026	35
36										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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor

# 0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37	2019	3,161		15	105	\$ 105	\$ 105
38							
39							
40							
41							
42							
43							
44							
45							
46							
47			3,558			(3,558)	
48							
49							
50							
51		14,698			2,264	2,264	26,747
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70		\$ 484,702	\$ 3,558		\$ 16,010	\$ 12,452	\$ 350,792

SEE ACCOUNTANTS' PREPARATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 16,330	\$	\$ 1,616	\$ 1,616	5-10 Yrs	\$ 11,697	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	40,755				5-10 Yrs	40,755	73
74	Allocated from Home Office	26,514						74
75	TOTALS	\$ 83,599	\$	\$ 1,616	\$ 1,616		\$ 52,452	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	Facility Use	2002 Chevy Venture	2016	\$ 1,565	\$	\$ 313	\$ 313	5	\$ 1,252	76
	Facility Use	2019 Dodge Caravan	2020	48,842		2,442	2,442	5	2,442	77
										78
79	Allocated from Home Office			2,944						79
80	TOTALS			\$ 53,351	\$	\$ 2,755	\$ 2,755		\$ 3,694	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)	\$ 649,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,381	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,823	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 406,938	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ 2,212 Description: Allocated from Home Office-Office Equipment

(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	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		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 prescripts				1,911		1,911	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	<b>TOTAL</b>			\$		\$	1,911		\$ 1,911	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

As of **6/30/2020**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 262,070	\$ 262,070	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>33,073</u> )	133,716	133,716	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,321)	(3,321)	6
7	Other Prepaid Expenses	14,857	14,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	1,566	1,566	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 408,888	\$ 408,888	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,369	13
14	Buildings, at Historical Cost	3,161	484,702	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	114,587	136,950	16
17	Accumulated Depreciation (book methods)	(57,997)	(406,938)	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 (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 79,751	\$ 242,083	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 488,639	\$ 650,971	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 52,370	\$ 52,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	116,788	116,788	29
30	Accrued Salaries Payable	38,511	38,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,195	2,195	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Advances from DHS</u>	18,822	18,822	36
37	<u>Intercompany Payable</u>	696,428	696,428	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 925,114	\$ 925,114	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	32,732	32,732	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 32,732	\$ 32,732	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 957,846	\$ 957,846	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (469,207)	\$ (306,875)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 488,639	\$ 650,971	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(500,579)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(500,579)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>31,372</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>31,372</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(469,207)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Joshua Manor

# 0040345

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 721,302	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 721,302	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(298)	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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ (298)	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	718	24
25	Interest and Other Investment Income***	965	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,683	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Allocated from Home Office-See Pg 19B</u>	2,523	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,523	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 725,210	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	88,225	31
32	Health Care	263,397	32
33	General Administration	297,651	33
<b>B. Capital Expense</b>			
34	Ownership	4,024	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,911	35
36	Provider Participation Fee	38,630	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 693,838	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	31,372	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 31,372	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 721,302	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 721,302	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A 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.

SEE ACCOUNTANTS' PREPARATION REPORT

**Joshua Manor**  
**0040345**  
**6/30/2020**

**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.

Joshua Manor  
0040345  
6/30/2020

SCH 19B

**XVII. INCOME STATEMENT**

**Line 28a. Income Allocated from Home Office**

Gain/ (Loss) on Sale of Fixed Assets	(1,335)
Miscellaneous Income	5
Rental Income	3,853

<b>Total Line 28a</b>	<b><u>2,523</u></b>
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Facility Name & ID Number **Joshua Manor**

# **0040345**

Report Period Beginning: **7/1/2019**

Ending:

**6/30/2020**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	675	744	20,975	28.19	3
4	Licensed Practical Nurses					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	1,649	1,748	20,771	11.88	15
16	Dishwashers					16
17	Maintenance Workers	512	734	11,847	16.14	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	926	1,033	37,142	35.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	297	316	8,429	26.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,300	1,468	29,950	20.40	29
30	Habilitation Aides (DD Homes)	15,018	16,470	193,989	11.78	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,377	22,513	\$ 323,103 *	\$ 14.35	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	27	\$ 1,485	L1, C3	35
36	Medical Director	Monthly	950	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	304	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	43	L11, C3	44
45	Social Service Consultant	21	1,260	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 4,042		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina Durbin	Administrator	0	\$ 14,667	Workers' Compensation Insurance	\$ 18,823	IDPH License Fee	\$	
Karla Rogers	Administrator	0	22,475	Unemployment Compensation Insurance	3,059	Advertising: Employee Recruitment		
				FICA Taxes	23,170	Health Care Worker Background Check		
				Employee Health Insurance	47,341	(Indicate # of checks performed )		
				Employee Meals	4,099	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	759	
				Life Insurance	638	Miscellaneous Dues & Fees	525	
				Other Employee Benefits	7,660			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 37,142					
B. Administrative - Other				Allocated from Home Office			11,424	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 116,214	
Allocated from Progressive Housing, Inc.			\$ 109,049					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 109,049	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				G. Schedule of Travel and Seminar**				
C. Professional Services				Description			Amount	
Vendor/Payee	Type		Amount	Description	Line #	Amount		
Paycor	Payroll Service		\$ 4,258			\$	Out-of-State Travel	
Janet Scellato	Accounting Consultant		3,781					
Wipfli	Accounting Services		437					
Hinshaw and Culbuertson, LLP	Legal Services		28				In-State Travel	
							342	
							Seminar Expense	
							651	
							Allocated from Home Office	
							2,213	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(For legal fee disclosure, see page 39 of instructions)			\$ 8,504					
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 3,206	

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

