

Facility Name & ID Number Joshua Manor

0040345 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 N/A

	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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	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	<u>5,607</u>			<u>5,607</u>	13
14	TOTALS	<u>5,607</u>			<u>5,607</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.01%

D. How many bed-hold days during this year were paid by the Department?

74 (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

Note : 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 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number

Joshua Manor

0040345

Report Period Beginning:

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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
	A. General Services										
1	Dietary	16,016	1,467	2,015	19,498		19,498		19,498		1
2	Food Purchase		32,909		32,909		32,909		32,909		2
3	Housekeeping		4,137	328	4,465		4,465	264	4,729		3
4	Laundry		1,938	284	2,222		2,222		2,222		4
5	Heat and Other Utilities			21,177	21,177		21,177	1,539	22,716		5
6	Maintenance	7,656		7,633	15,289		15,289	967	16,256		6
7	Other (specify):*										7
8	TOTAL General Services	23,672	40,451	31,437	95,560		95,560	2,770	98,330		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	229,754	9,946	1,697	241,397		241,397	2	241,399		10
10a	Therapy			2,429	2,429		2,429		2,429		10a
11	Activities		1,313		1,313		1,313		1,313		11
12	Social Services			2,287	2,287		2,287		2,287		12
13	CNA Training										13
14	Program Transportation			23,320	23,320		23,320		23,320		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	229,754	11,259	29,733	270,746		270,746	2	270,748		16
	C. General Administration										
17	Administrative										17
18	Directors Fees			2,498	2,498		2,498		2,498		18
19	Professional Services			11,984	11,984		11,984	4,297	16,281		19
20	Dues, Fees, Subscriptions & Promotions			1,292	1,292		1,292	835	2,127		20
21	Clerical & General Office Expenses		2,107	5,371	7,478		7,478	46,889	54,367		21
22	Employee Benefits & Payroll Taxes			39,471	39,471		39,471	7,361	46,832		22
23	Inservice Training & Education			29	29		29		29		23
24	Travel and Seminar			2,155	2,155		2,155	963	3,118		24
25	Other Admin. Staff Transportation			1,703	1,703		1,703	190	1,893		25
26	Insurance-Prop.Liab.Malpractice			3,699	3,699		3,699	1,249	4,948		26
27	Other (specify):*										27
28	TOTAL General Administration		2,107	68,202	70,309		70,309	61,784	132,093		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	253,426	53,817	129,372	436,615		436,615	64,556	501,171		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

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Report Period Beginning:

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Ending:

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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	
	D. Ownership											
30	Depreciation			16,708	16,708		16,708	2,382	19,090			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,941	33,941		33,941	305	34,246			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							755	755			34
35	Rent-Equipment & Vehicles							151	151			35
36	Other (specify):*											36
37	TOTAL Ownership			50,649	50,649		50,649	3,593	54,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,264	38,264		38,264		38,264			42
43	Other (specify):* Non-Allowable Cos			273,400	273,400		273,400	(273,400)				43
44	TOTAL Special Cost Centers			311,664	311,664		311,664	(273,400)	38,264			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	253,426	53,817	491,685	798,928		798,928	(205,251)	593,677			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**

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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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (273,302)	43		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	(17)	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	(98)	43		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				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 <u>See Pg 5A</u>				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (273,417)		\$	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	2	
		Amount	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)	68,166		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 68,166		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (205,251)		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.

		1	2	3	4	
		Yes	No	Amount	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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 Attached Related Party Schedule Sch 6A		See Attached Related Party Schedule Sch 6A		
See Attached Schedule 7A						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18 Board Fees	\$ 357	Progressive Housing, Inc.	100.00%	\$ 357	\$	1
2	V	19 Professional Fees	723	Progressive Housing, Inc.	100.00%	723		2
3	V	20 License, Dues	1	Progressive Housing, Inc.	100.00%	1		3
4	V	21 General Office	275	Progressive Housing, Inc.	100.00%	275		4
5	V	23 Inservices Travel		Progressive Housing, Inc.	100.00%			5
6	V	24 Travel Seminar	34	Progressive Housing, Inc.	100.00%	34		6
7	V	32 Interest Income	16	Progressive Housing, Inc.	100.00%	16		7
8	V	43 Non-allowable		Progressive Housing, Inc.	100.00%			8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,406			\$ 1,406	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	Board Fees	\$ 2,141	Progressive Housing, Inc.	100.00%	\$ 2,141	\$	15
16	V	19	Professional Fees	10,440	Progressive Housing, Inc.	100.00%	10,440		16
17	V	20	License, Dues	1	Progressive Housing, Inc.	100.00%	1		17
18	V	21	General Office	1,951	Progressive Housing, Inc.	100.00%	1,951		18
19	V	23	Inservices Travel		Progressive Housing, Inc.	100.00%			19
20	V	24	Travel Seminar	258	Progressive Housing, Inc.	100.00%	258		20
21	V	32	Interest Income	139	Progressive Housing, Inc.	100.00%	139		21
22	V	43	Non-allowable	(73)	Progressive Housing, Inc.	100.00%	(73)		22
23	V	24	Travel Seminar	102	Progressive Housing, Inc.	100.00%	102		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			\$ 14,959			\$ 14,959	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 <u>Housekeeping</u>	\$	<u>Center For Residential Management</u>	<u>Parent Co.</u>	\$ 264	\$ 264
16	V	5 <u>Utilities</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	1,539	1,539
17	V	6 <u>Maintenance</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	967	967
18	V	10 <u>Nursing Supplies</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	2	2
19	V	17 <u>Administrative Cost</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
20	V	19 <u>Professional Fees</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	4,297	4,297
21	V	20 <u>Dues, Fees</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	835	835
22	V	21 <u>Clerical & General</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	46,889	46,889
23	V	22 <u>Employment Benefits</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	7,361	7,361
24	V	23 <u>Inservices Education</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
25	V	24 <u>Travel Seminar</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	963	963
26	V	25 <u>Other Admin Staff Trans.</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	190	190
27	V	26 <u>Insurance</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	1,249	1,249
28	V	30 <u>Depreciation</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	2,382	2,382
29	V	32 <u>Interest</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	322	322
30	V	33 <u>Real Estate Taxes</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
31	V	34 <u>Rent</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	755	755
32	V	35 <u>Equipment Rental</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	151	151
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 68,166	\$ * 68,166

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

RELATED PARTY SCHEDULE

Schedule VII - Related Parties

Page 6, Section A, Column 2 Related Facilities

NAME	FACILITY NAME	CITY	STATE
Progressive Housing Inc.	Lakeview Living Center	Chicago	IL
	Sparta Terrace	Sparta	IL
	Ellner Terrace	Evansville	IL
	Taylorville Terrace	Taylorville	IL
Progressive Housing Inc.	Aviston Terrace	Aviston	IL
	Briarbrook Place	East Peoria	IL
	Harris Place	East Peoria	IL
	Joshua Manor	Hoyleton	IL
	Terra Estates	Hoyleton	IL
	Park Place	Pana	IL
	Cardinal	Woodlawn	IL
	Western Gardens	MT. Vernon	IL
	Galaxy	Woodlawn	IL
	Bill Goat Hill	MT. Vernon	IL
	Country Club Hill	Country Club Hills	IL
	Lee street	Country Club Hills	IL
	Baker Street	Country Club Hills	IL
	182nd Street	Country Club Hills	IL
	Osage	Park Forest	IL
	Oakwood	Park Forest	IL
	Blair	Park Forest	IL
	Lowell	Hazelcrest	IL
	Marquette	Park Forest	IL
	Cherry	Park Forest	IL
Luella	Sauk Village	IL	
Olivia	Sauk Village	IL	
Huron	Park Forest	IL	
Wilshire	Park Forest	IL	
Constance	Sauk Village	IL	

Schedule VII - Related Parties

Page 6, Section A, Column 3 Other Related Business Entities

Name	City	Type of Business
Center for Residential Management	Peoria	Management Company
Progressive Housing, Inc.	Peoria	ICF/DD Provider

Facility Name & ID Number

Joshua Manor

#

0040345

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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		
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Ronald Schroeder	Secretary	Board Member	None	6,427	3Hrs/MTG	1.00	Dir. Fees	\$ 373	L18,C8	1
2	Shawn Jeffers	Chairman	Board Member	None	7,562	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	2
3	Edward Childers	Vice Chairman	Board Member	None	10,965	3Hrs/MTG	1.00	Dir. Fees	635	L18,C8	3
4	Robert Bauer	Director	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	4
5	Cora Flota	Director	Board Member	None	1,512	3Hrs/MTG	1.00	Dir. Fees	88	L18,C8	5
6	Orland Bauer	Treasurer	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,498		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

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SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.	Ron Schroder	Edward Childers	Robert Bauer	Cora Flota	Orland Bauer	Shawn Jeffers	Total
Lakeview Living Center	630	1,072	812	150	812	739	4,215
Sparta Terrace	373	635	482	88	482	438	2,498
Ellner Terrace	373	635	482	88	482	438	2,498
Taylorville Terrace	373	635	482	88	482	438	2,498
Aviston Terrace	373	635	482	88	482	438	2,498
Briarbrook Place	373	635	482	88	482	438	2,498
Harris Place	373	635	482	88	482	438	2,498
Joshua Manor	373	635	482	88	482	438	2,498
Terra Estates	373	635	482	88	482	438	2,498
Park Place	373	635	482	88	482	438	2,498
Cardinal	186	318	241	44	241	219	1,249
Western Gardens	186	318	241	44	241	219	1,249
Galaxy	186	318	241	44	241	219	1,249
Bill Goat Hill	186	318	241	44	241	219	1,249
Country Club Hill	140	238	180	33	181	164	936
Lee Street	140	238	180	33	181	164	936
Baker Street	140	238	180	34	180	164	936
182nd Street	140	238	180	34	180	164	936
Osage	140	238	180	34	180	164	936
Oakwood	140	238	180	34	180	164	936
Blair	140	239	180	33	180	164	936
Lowell	140	239	180	33	180	164	936
Marquette	140	239	180	33	180	164	936
Cherry	140	239	180	33	180	164	936
Luella	140	238	181	33	180	164	936
Olivia	140	238	181	33	180	164	936
Huron	141	238	180	33	180	164	936
Wilshire	141	238	180	33	180	164	936
Constance	107	205	164	16	164	147	803
Total PHI	6,800	11,600	8,800	1,600	8,800	8,000	45,600

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Report Period Beginning: 07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Progressive Housing, Inc.
 Street Address PO Box 10528
 City / State / Zip Code Peoria, IL. 61612
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

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	18	Board Fees	Number of Beds	287	\$ 6,400	\$	16	\$ 357	1
2	19	Professional Fees	Number of Beds	287	12,968		16	723	2
3	20	License, Dues	Number of Beds	287	10		16	1	3
4	21	General Office	Number of Beds	287	4,934		16	275	4
5	23	Inservices Travel	Number of Beds	287			16	0	5
6	24	Travel Seminar	Number of Beds	287	609		16	34	6
7	32	Interest Income	Number of Beds	287	285		16	16	7
8	43	Non-allowable	Number of Beds	287			16	0	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 25,206	\$		\$ 1,406	25

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Progressive Housing, Inc.
 Street Address PO Box 10528
 City / State / Zip Code Peoria, IL. 61612
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

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	18	Board Fees	Number of Beds	293	\$ 39,200	\$	16	\$ 2,141	1
2	19	Professional Fees	Number of Beds	293	191,187		16	10,440	2
3	20	License, Dues	Number of Beds	293	10		16	1	3
4	21	General Office	Number of Beds	293	35,726		16	1,951	4
5	23	Inservices Travel	Number of Beds	293			16		5
6	24	Travel Seminar	Number of Beds	293	4,722		16	258	6
7	32	Interest Income	Number of Beds	293	2,540		16	139	7
8	43	Non-allowable	Number of Beds	293	(1,344)		16	(73)	8
9	24	Travel Seminar	Number of Facility	13	1,329		1	102	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 273,370	\$		\$ 14,959	25

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Center for Residential Management
 Street Address PO Box 10528
 City / State / Zip Code Peoria, IL. 61612
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

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	Revenue	12,610,469	\$ 4,888	\$	680,765	\$ 264	1
2	5	Utilities	Revenue	12,610,469	28,505		680,765	1,539	2
3	6	Maintenance	Revenue	12,610,469	17,904		680,765	967	3
4	10	Nursing Supplies	Revenue	12,610,469	29		680,765	2	4
5	17	Administrative Cost	Revenue	12,610,469			680,765		5
6	19	Professional Fees	Revenue	12,610,469	79,603		680,765	4,297	6
7	20	Dues, Fees	Revenue	12,610,469	15,474		680,765	835	7
8	21	Clerical & General	Revenue	12,610,469	868,566	741,167	680,765	46,889	8
9	22	Employment Benefits	Revenue	12,610,469	136,351		680,765	7,361	9
10	23	Inservices Education	Revenue	12,610,469			680,765		10
11	24	Travel Seminar	Revenue	12,610,469	17,846		680,765	963	11
12	25	Other Admin Staff Trans.	Revenue	12,610,469	3,527		680,765	190	12
13	26	Insurance	Revenue	12,610,469	23,128		680,765	1,249	13
14	30	Depreciation	Revenue	12,610,469	44,128		680,765	2,382	14
15	32	Interest	Revenue	12,610,469	5,957		680,765	322	15
16	33	Real Estate Taxes	Revenue	12,610,469			680,765		16
17	34	Rent	Revenue	12,610,469	13,987		680,765	755	17
18	35	Equipment Rental	Revenue	12,610,469	2,792		680,765	151	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,262,685	\$ 741,167		\$ 68,166	25

Facility Name & ID Number

Joshua Manor

0040345

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 519,382	\$ 481,123	08/15/26	6.7500	\$ 32,379	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Vendor Finance Charge		X	Working Capital							353	6					
7	Allocation from Parent	X		Working Capital							477	7					
8	Amort of Loan Cost		X	Facility Acquisition							1,054	8					
9	TOTAL Facility Related						\$ 519,382	\$ 481,123			\$ 34,263	9					
	B. Non-Facility Related*																
10												10					
11	Offset Interest Income										(17)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (17)	14					
15	TOTALS (line 9+line14)						\$ 519,382	\$ 481,123			\$ 34,246	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.)

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 2009 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.)	2009	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 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:	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2009 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 2009 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 2009.

(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. _____	_____	\$ _____	\$ _____
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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:

07/01/2009 Ending:

06/30/2010

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>46,100</u>	<u>1993</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	46,100		\$ 20,000	3

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$ 10,150	40	\$ 10,150		\$ 174,241	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	56	15	56		1,684	10
11	Carpet		1997		1,055	70	15	70		809	11
12	Tile		1999		849	57	15	57		595	12
13	Shower		1999		2,789	186	15	186		1,952	13
14	Tile		2004		997	66	15	66		371	14
15	Bathroom Tile		2006		420	28	15	28		121	15
16	Kitchen Remodel		2006		1,239	83	15	83		303	16
17	Kitchen Remodel		2006		1,287	86	15	86		307	17
18	Kitchen Remodel		2006		1,955	130	15	130		467	18
19	Bedroom Remodel		2007		10,192	680	15	680		2,340	19
20	Bathroom Remodel		2007		695	46	15	46		130	20
21	Gazebo		2007		1,796	120	15	120		309	21
22	Roof Repair		2008		15,757	1,051	15	1,051		2,223	22
23	Roof Repair		2008		335	22	15	22		45	23
24	Flooring		2008		225	15	15	15		30	24
25	Garage Repair		2008		529	35	15	35		62	25
26	Building Improvements - Painting		2010		717	20	15	20		20	26
27	Living Room Flooring		2010		1,252	21	15	21		21	27
28	Living Room and Laundry Flooring		2010		797	13	15	13		13	28
29	Living Room and Bathroom Flooring Tile		2010		813	9	15	9		9	29
30											30
31											31
32								774	774		32
33	Allocation from Parent Co.										33
34											34
35											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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	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)	\$ 452,973	\$ 12,944		\$ 13,718	\$ 774	\$ 187,642	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:

07/01/2009

Ending:

06/30/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 29,913	\$ 3,194	\$ 3,194	\$	5-10Yrs	\$ 12,954	71
72	Current Year Purchases	2,585	150	150		5-10Yrs	150	72
73	Fully Depreciated Assets	13,021				5-10Yrs	13,021	73
74	Allocated From Parent Co.			1,608	1,608			74
75	TOTALS	\$ 45,519	\$ 3,344	\$ 4,952	\$ 1,608		\$ 26,125	75

D. Vehicle Depreciation (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 Trans	2003 Mercury Sable	2003	\$ 16,961	\$	\$	\$	5	\$ 16,113	76
77	Resident Trans	94 Ford Van	2008	2,100	420	420		5	875	77
78										78
79										79
80	TOTALS			\$ 19,061	\$ 420	\$ 420	\$		\$ 16,988	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 537,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,090	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,382	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 230,755	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

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	Allocation from Parent Co.				755			5
6								6
7	TOTAL				\$ 755			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease 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?

16. Rental Amount for movable equipment: \$ 151 Description: Allocation from Parent Co. Postage Meter, Lift YES NO

(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	TOTAL		\$	\$	21

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. _____ /2011 \$ N/A

13. _____ /2012 \$ N/A

14. _____ /2013 \$ N/A

* 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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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	L10, C3	visits		22	977		22	977	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Eye Care</u>	L10, C 3			4	401		4	401	12
13	Other (specify): _____									13
14	TOTAL			\$	26	\$ 1,378	\$	26	\$ 1,378	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning: 07/01/2009

Ending:

06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010

(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	\$ 300	\$ 300	1
2	Cash-Patient Deposits	13,919	13,919	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (6,325))	413,899	413,899	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	142	142	6
7	Other Prepaid Expenses	1,533	1,533	7
8	Accounts Receivable (owners or related parties)	1,135,415	1,135,415	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,565,208	\$ 1,565,208	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	452,973	452,973	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	64,580	64,580	16
17	Accumulated Depreciation (book methods)	(230,755)	(230,755)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	75,888	75,888	21
22	Other Long-Term Assets (spec <u>Loan Cost</u>)	10,424	10,424	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 393,110	\$ 393,110	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,958,318	\$ 1,958,318	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 93,409	\$ 93,409	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,919	13,919	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,335	14,335	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,111	12,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Exp., Accrued Workshop</u>	109,138	109,138	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 242,912	\$ 242,912	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	481,123	481,123	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)	\$ 481,123	\$ 481,123	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 724,035	\$ 724,035	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,234,283	\$ 1,234,283	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,958,318	\$ 1,958,318	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,056,807	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,056,807	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	177,476	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)	\$ 177,476	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,234,283	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 680,765	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 680,765	3
B. Ancillary Revenue			
4	Day Care	295,609	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,609	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	13	24
25	Interest and Other Investment Income***	17	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	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)	\$ 976,404	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	95,560	31
32	Health Care	270,746	32
33	General Administration	70,309	33
B. Capital Expense			
34	Ownership	50,649	34
C. Ancillary Expense			
35	Special Cost Centers	273,400	35
36	Provider Participation Fee	38,264	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 798,928	40
41	Income before Income Taxes (line 30 minus line 40)**	177,476	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 177,476	43

* 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	06/30/2010

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	492	521	11,617	22.30	3
4	Licensed Practical Nurses	41	79	1,081	13.68	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	1,637	1,865	16,016	8.59	15
16	Dishwashers					16
17	Maintenance Workers	581	651	7,656	11.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,219	1,336	22,492	16.84	29
30	Habilitation Aides (DD Homes)	22,212	23,009	194,564	8.46	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,182	27,461	\$ 253,426 *	\$ 9.23	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	23	\$ 1,746	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	319	L10, C3	39
40	Physical Therapy Consultant	26	474	L10A, C3	40
41	Occupational Therapy Consultant	71	1,669	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	286	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	34	2,287	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	158	\$ 6,781		49

C. CONTRACT NURSES

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

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	
N/A Allocated From CRM				Workers' Compensation Insurance	\$ 10,245	IDPH License Fee	\$	
				Unemployment Compensation Insurance	5,934	Advertising: Employee Recruitment		
				FICA Taxes	19,178	Health Care Worker Background Check	220	
				Employee Health Insurance	3,611	(Indicate # of checks performed <u>22</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Vehicle License	14	
				Employee Moral	405	IHCA Dues	883	
				403B Retirement Contribution		Miscellaneous Dues & Fees	175	
				Drug Test	98			
						Allocation from Parent Co.	835	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,127	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 46,832			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Allocated from Center For Residential Management				N/A			Out-of-State Travel	\$ 9
							In-State Travel	1,416
							Allocation from Parent Co.	847
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	730
							Allocation from Parent Co.	116
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,118
Schuyler Roche	Legal		\$ 139					
Wells Fargo	Bond Trustee		164					
Krieg, Devault	Legal		2,588					
Personnel Planners	UC Consultant		597					
Heinold-Banwart, LTD	Accounting		7,626					
Barbara Weiner	Legal		82					
Wildman, Harrold, Allen	Legal		778					
Westervelt, Johnson, Nicoll	Legal		10					
Allocation from Parent Co.			4,297					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 16,281	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Joshua Manor# 0040345Report Period Beginning: 07/01/2009Ending: 06/30/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$883
- (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? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,882 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,264
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. \$ 0 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? 83
- 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? N/A
- 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.