



Facility Name & ID Number Joshua Manor

# 0040345 Report Period Beginning: 7/1/17 Ending: 6/30/18

**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	5,840	6
7	16	TOTALS	16	5,840	7

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

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,597			4,597	13
14	TOTALS	4,597			4,597	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.72%**

**D. How many bed reserve days during this year were paid by the Department?**  
39 (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: 6/30/2018 Fiscal Year: 6/30/2018

\* 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: 7/1/17 Ending: 6/30/18

**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	15,232	1,082	749	17,063		17,063		17,063		1
2	Food Purchase		25,345		25,345		25,345		25,345		2
3	Housekeeping		2,066		2,066		2,066	11	2,077		3
4	Laundry		1,129		1,129		1,129		1,129		4
5	Heat and Other Utilities			12,588	12,588		12,588	16	12,604		5
6	Maintenance	15,782	1,433	3,455	20,670		20,670	3,975	24,645		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	31,014	31,055	16,792	78,861		78,861	4,002	82,863		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			750	750		750		750		9
10	Nursing and Medical Records	223,178	4,486	1,991	229,655		229,655		229,655		10
10a	Therapy										10a
11	Activities		453		453		453		453		11
12	Social Services			1,624	1,624		1,624		1,624		12
13	CNA Training										13
14	Program Transportation			6,187	6,187		6,187		6,187		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	223,178	4,939	10,552	238,669		238,669		238,669		16
	<b>C. General Administration</b>										
17	Administrative	27,822		150,088	177,910		177,910	(150,088)	27,822		17
18	Directors Fees							4,639	4,639		18
19	Professional Services			4,233	4,233		4,233	8,831	13,064		19
20	Dues, Fees, Subscriptions & Promotions			581	581		581	3,424	4,005		20
21	Clerical & General Office Expenses	5,695	1,951	6,221	13,867		13,867	65,994	79,861		21
22	Employee Benefits & Payroll Taxes			99,497	99,497		99,497	9,782	109,279		22
23	Inservice Training & Education			2,264	2,264		2,264		2,264		23
24	Travel and Seminar			713	713		713	1,711	2,424		24
25	Other Admin. Staff Transportation			7,160	7,160		7,160	1,335	8,495		25
26	Insurance-Prop.Liab.Malpractice			8,619	8,619		8,619	657	9,276		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	33,517	1,951	279,376	314,844		314,844	(53,715)	261,129		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	287,709	37,945	306,720	632,374		632,374	(49,713)	582,661		29

\*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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,638	4,638		4,638	12,513	17,151			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,103	20,103		20,103	8,283	28,386			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			24,741	24,741		24,741	20,796	45,537			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,018		5,018		5,018		5,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,012	28,012		28,012		28,012			42
43	Other (specify):* <b>Disallowed Costs</b>											43
44	<b>TOTAL Special Cost Centers</b>		5,018	28,012	33,030		33,030		33,030			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	287,709	42,963	359,473	690,145		690,145	(28,917)	661,228			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:

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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	
	<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	10,810	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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 See Page 5A	(39,727)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (28,917)		\$	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>	\$ (28,917)		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	
							52

SEE ACCOUNTANTS' PREPARATION REPORT

Joshua Manor

ID# 0040345

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (43,701)	43	1
2	Expense Building Improvements under \$2,500	3,974	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(39,727)		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>11</u>	\$ <u>11</u>	<u>1</u>
2	V	<u>5 Utilities</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>16</u>	<u>16</u>	<u>2</u>
3	V	<u>6 Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1</u>	<u>1</u>	<u>3</u>
4	V	<u>18 Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>4,639</u>	<u>4,639</u>	<u>4</u>
5	V	<u>19 Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>8,831</u>	<u>8,831</u>	<u>5</u>
6	V	<u>20 Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>3,424</u>	<u>3,424</u>	<u>6</u>
7	V	<u>21 Clerical and General Office</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>65,994</u>	<u>65,994</u>	<u>7</u>
8	V	<u>22 Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>9,782</u>	<u>9,782</u>	<u>8</u>
9	V	<u>24 Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,711</u>	<u>1,711</u>	<u>9</u>
10	V	<u>25 Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,335</u>	<u>1,335</u>	<u>10</u>
11	V	<u>26 Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>657</u>	<u>657</u>	<u>11</u>
12	V	<u>30 Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,703</u>	<u>1,703</u>	<u>12</u>
13	V	<u>32 Interest</u>	<u>1,207</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>9,490</u>	<u>8,283</u>	<u>13</u>
14	Total		\$ <u>1,207</u>			\$ <u>107,594</u>	\$ * <u>106,387</u>	<u>14</u>

\* 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	35 Equipment Rental	2,408	Progressive Housing, Inc.	100.00%	\$ 2,408	\$	15
16	V	43 Non-Allowable Expenses	554	Progressive Housing, Inc.	100.00%	44,255		43,701 16
17	V	17 Administrative	150,088	Progressive Housing, Inc.	100.00%			(150,088) 17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 153,050			\$ 46,663	\$ *	(106,387) 39

\* 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:

7/1/17

Ending:

6/30/18

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

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## 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	8,877	3Hrs/MTG	1.00	Dir. Fees	\$ 613	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	8,877	3Hrs/MTG	1.00	Dir. Fees	613	L18,C8	7
8											8
9					Misc Expenses				348		9
10											10
11											11
12											12
13								TOTAL	\$ 4,639		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

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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 20180 Governors Dr., Suite 300  
 City / State / Zip Code Olympia Fields, IL 60461  
 Phone Number (708) 283-1530  
 Fax Number (708) 283-2470

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.	254	28	182	16	\$ 11	1
2	5	Utilities	Bed Capacity/Specific Alloc.	254	28	258	16	16	2
3	6	Maintenance	Bed Capacity/Specific Alloc.	254	28	17	16	1	3
4	18	Director Fees	Bed Capacity/Specific Alloc.	254	28	71,792	16	4,639	4
5	19	Professional Services	Bed Capacity/Specific Alloc.	254	28	141,174	16	8,831	5
6	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	254	28	53,223	16	3,424	6
7	21	Clerical and General Office	Bed Capacity/Specific Alloc.	254	28	1,013,305	16	65,994	7
8	22	Employee Benefits	Bed Capacity/Specific Alloc.	254	28	160,293	16	9,782	8
9	24	Travel and Seminar	Bed Capacity/Specific Alloc.	254	28	22,429	16	1,711	9
10	25	Auto Expense	Bed Capacity/Specific Alloc.	254	28	20,635	16	1,335	10
11	26	Insurance	Bed Capacity/Specific Alloc.	254	28	10,391	16	657	11
12	30	Depreciation	Bed Capacity/Specific Alloc.	254	28	26,185	16	1,703	12
13	32	Interest	Bed Capacity/Specific Alloc.	254	28	121,615	16	9,490	13
14	35	Equipment Rental	Bed Capacity/Specific Alloc.	254	28	1,168	16	2,408	14
15	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	254	28	843,871	16	44,255	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,486,538	\$ 844,767	\$ 154,257	25

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6/30/18

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 793,404	\$	08/15/26	6.7500	\$ 16,961	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 793,404	\$			\$ 16,961	9						
<b>B. Non-Facility Related*</b>																		
10									Amortization		3,142	10						
11									Home Office Allocation		9,490	11						
12									Interest Income Offset-HO		(1,207)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 11,425	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 793,404	\$			\$ 28,386	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.)

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 2017 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 2018 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:	2013	N/A	8
	2014	N/A	9
	2015	N/A	10
	2016	N/A	11
	2017	N/A	12

N/A - Not for profit entity

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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

**2017 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 2017 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 2017.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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:

7/1/17

Ending:

6/30/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

N/A

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Rows include Facility (46,100 sq ft, 1993, \$20,000), Allocated from Home Office (7,076), and TOTALS (46,100, \$27,076).

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 255,487	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	66	66	899	14
15	Bathroom Tile		2006	420		15	28	28	345	15
16	Kitchen Remodel		2006	1,239		15	83	83	967	16
17	Kitchen Remodel		2006	1,287		15	86	86	995	17
18	Kitchen Remodel		2006	1,955		15	130	130	1,507	18
19	Bedroom Remodel		2007	10,192		15	680	680	7,780	19
20	Bathroom Remodel		2007	695		15	46	46	498	20
21	Gazebo		2007	1,796		15	120	120	1,269	21
22	Roof Repair		2008	15,757		15	1,050	1,050	10,629	22
23	Roof Repair		2008	335		15	22	22	221	23
24	Flooring		2008	225		15	15	15	150	24
25	Garage Repair		2008	529		15	35	35	342	25
26	Building Improvements - Painting		2010	717		15	48	48	404	26
27	Living Room Flooring		2010	1,252		15	83	83	685	27
28	Living Room and Laundry Flooring		2010	797		15	53	53	437	28
29	Living Room and Bathroom Flooring Tile		2010	813		15	54	54	441	29
30	Install 5 ton condensing unit		2010	2,800		15	187	187	1,496	30
31	New Furnace		2012	2,100		15	140	140	887	31
32	New A/C Condesner and Coil		2012	3,600		15	240	240	1,460	32
33	New Sprinkler Heads		2012	1,420		15	95	95	486	33
34	Gutters and Extensions		2013	1,675		15	112	112	550	34
35	New Furnace		2013	2,275		15	152	152	722	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:

7/1/17

Ending:

6/30/18

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		\$	\$		\$	\$	\$	37
38								38
39								39
40			4,638			(4,638)		40
41								41
42								42
43								43
44								44
45								45
46								46
47		13,051			1,703	1,703	21,381	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		\$ 479,894	\$ 4,638		\$ 15,378	\$ 10,740	\$ 318,005	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number **Joshua Manor**

# **0040345**

Report Period Beginning:

**7/1/17**

Ending:

**6/30/18**

**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	\$ 7,750	\$	\$ 813	\$ 813	5-10 Yrs	\$ 5,062	71
72	Current Year Purchases	10,700		960	960	10 yrs	6,100	72
73	Fully Depreciated Assets	39,133				5-10 Yrs	39,133	73
74	Allocated from Home Office	23,449						74
75	TOTALS	\$ 81,032	\$	\$ 1,773	\$ 1,773		\$ 50,295	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	2005 Ford Taurus SE	2005	17,283			\$	5	\$ 17,283	76
77										77
78										78
79	Allocated from Home Office			2,809						79
80	TOTALS			\$ 20,092	\$	\$	\$		\$ 17,283	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)	\$ 608,094	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,638	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,513	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 385,583	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 0 Description: N/A  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	N/A		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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				5,018		5,018	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	5,018		\$ 5,018	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

Facility Name & ID Number **Joshua Manor**

# **0040345**

Report Period Beginning: **7/1/17**

Ending:

**6/30/18**

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

As of **6/30/18**

(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	\$ 82,167	\$ 82,167	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>32,023</u> )	105,888	105,888	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,598	3,598	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 191,653	\$ 191,653	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,076	13
14	Buildings, at Historical Cost		479,894	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	66,198	101,124	16
17	Accumulated Depreciation (book methods)	(51,700)	(385,583)	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 (spe <u>Loan Costs</u> )			22
23	Other(specify): <u>Deposits</u>	1,504	1,504	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 36,002	\$ 224,015	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 227,655	\$ 415,668	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 11,850	\$ 11,850	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,336	26,336	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,388	1,388	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>Accrued Expenses</u>	30,630	30,630	36
37	<u>Intercompany Payable</u>	645,539	645,539	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 715,743	\$ 715,743	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 715,743	\$ 715,743	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (488,088)	\$ (300,075)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 227,655	\$ 415,668	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>(967,951)</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>(967,951)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>479,863</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>479,863</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>(488,088)</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: 7/1/17

Ending: 6/30/18

**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	\$ 574,757	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 574,757	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		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	6,084	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,084	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Extraordinary Income</u>	520,560	28
28a	<u>Properties not in Service</u>	68,606	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 589,166	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,170,008	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	78,861	31
32	Health Care	238,669	32
33	General Administration	314,844	33
<b>B. Capital Expense</b>			
34	Ownership	24,741	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,018	35
36	Provider Participation Fee	28,012	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 690,145	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	479,863	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 479,863	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 574,757	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>	\$ 574,757	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**  
**6/30/18**

**SCH 19A**

Schedule XVII  
Page 19

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

Facility Name & ID Number **Joshua Manor**

# **0040345**

Report Period Beginning:

7/1/17

Ending:

6/30/18

**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	640	17,348	24.37	3
4	Licensed Practical Nurses	211	2,962	13.97	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	1,466	15,232	10.39	15
16	Dishwashers				16
17	Maintenance Workers	919	15,782	14.85	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	888	27,822	27.91	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	198	5,695	25.65	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	385	8,383	20.20	28
29	Resident Services Coordinator	920	18,890	18.27	29
30	Habilitation Aides (DD Homes)	15,093	175,595	10.47	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	20,720	22,895	\$ 287,709 *	\$ 12.57 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	20	\$ 749	L1, C3 35
36	Medical Director	Monthly	750	L9, C3 36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly	1,207	L10, C3 38
39	Pharmacist Consultant	Monthly	324	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			44
45	Social Service Consultant	20	1,624	L12, C3 45
46	Other(specify) <u>Dental</u>	Monthly	460	L10, C3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	40	\$ 5,114	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	\$ 12,232	Workers' Compensation Insurance	\$ 21,999	IDPH License Fee	\$	
Karla Rogers	Administrator	0	15,590	Unemployment Compensation Insurance	5,457	Advertising: Employee Recruitment		
				FICA Taxes	21,291	Health Care Worker Background Check		
				Employee Health Insurance	45,517	(Indicate # of checks performed <u>6</u> )		
				Employee Meals	4,199	Patient Background Checks	<u>2</u>	
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	256	
				Life Insurance	492	Miscellaneous Dues & Fees	325	
				Other Employee Benefits	542			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,822					
B. Administrative - Other				Allocated from Home Office			9,782	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 109,279	
Allocated from Progressive Housing, Inc.			\$ 150,088					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,088	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description			Line #	Amount
Vendor/Payee	Type		Amount					
Paycor	Payroll Service		\$ 4,145	N/A				
MyStaffingPro	Payroll Service		116					
Misc Credit			(28)					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 4,233	TOTAL			\$	
				G. Schedule of Travel and Seminar**				
Description			Amount	Out-of-State Travel			\$	
In-State Travel			86	Seminar Expense			627	
Allocated from Home Office			1,711	Entertainment Expense			( )	
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 2,424					

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

\*\*See instructions.

