

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0040345</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Joshua Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>100 West Locust St</u> <u>Hoyleton</u> <u>62803</u>			
Number City Zip Code			
County: <u>Washington</u>			
Telephone Number: <u>(618) 493-6071</u> Fax # <u>(618) 493-6145</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>05/01/1993</u>			
Type of Ownership:			
☒ VOLUNTARY,NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code <u>501 C (3)</u>			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Larry Templin</u>			
Telephone Number: <u>630-361-2868</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Lawrence A. Manson</u>	
		(Title) <u>Chief Executive Officer</u>	
		Paid Preparer	
		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
		(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>	
		(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	
		(Telephone) <u>(630) 361-2868</u> Fax # ()	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	5,112			5,112	13
14	TOTALS	5,112			5,112	14

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

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/01/1993

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	20,771	1,504	1,485	23,760		23,760		23,760			1
2	Food Purchase		27,507		27,507		27,507		27,507			2
3	Housekeeping		3,370		3,370		3,370	13	3,383			3
4	Laundry		1,441		1,441		1,441		1,441			4
5	Heat and Other Utilities			12,805	12,805		12,805		12,805			5
6	Maintenance	11,847	3,530	3,965	19,342		19,342	905	20,247			6
7	Other (specify):*											7
8	TOTAL General Services	32,618	37,352	18,255	88,225		88,225	918	89,143			8
	B. Health Care and Programs											
9	Medical Director			950	950		950		950			9
10	Nursing and Medical Records	244,914	8,462	304	253,680		253,680		253,680			10
10a	Therapy											10a
11	Activities		234	43	277		277		277			11
12	Social Services			1,260	1,260		1,260		1,260			12
13	CNA Training											13
14	Program Transportation			7,230	7,230		7,230		7,230			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	244,914	8,696	9,787	263,397		263,397		263,397			16
	C. General Administration											
17	Administrative	37,142		109,049	146,191		146,191	(109,049)	37,142			17
18	Directors Fees							4,375	4,375			18
19	Professional Services			8,504	8,504		8,504	6,892	15,396			19
20	Dues, Fees, Subscriptions & Promotions			1,284	1,284		1,284	2,500	3,784			20
21	Clerical & General Office Expenses	8,429	2,441	9,330	20,200		20,200	71,949	92,149			21
22	Employee Benefits & Payroll Taxes			104,790	104,790		104,790	11,424	116,214			22
23	Inservice Training & Education			1,927	1,927		1,927		1,927			23
24	Travel and Seminar			993	993		993	2,213	3,206			24
25	Other Admin. Staff Transportation			4,385	4,385		4,385	1,150	5,535			25
26	Insurance-Prop.Liab.Malpractice			9,377	9,377		9,377	464	9,841			26
27	Other (specify):*											27
28	TOTAL General Administration	45,571	2,441	249,639	297,651		297,651	(8,082)	289,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	323,103	48,489	277,681	649,273		649,273	(7,164)	642,109			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			3,558	3,558		3,558	16,823	20,381			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			466	466		466	(466)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,212	2,212			35
36	Other (specify):*											36
37	TOTAL Ownership			4,024	4,024		4,024	18,569	22,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,911		1,911		1,911		1,911			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,630	38,630		38,630		38,630			42
43	Other (specify):* Disallowed Costs											43
44	TOTAL Special Cost Centers		1,911	38,630	40,541		40,541		40,541			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	323,103	50,400	320,335	693,838		693,838	11,405	705,243			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,559	30		9
10	Interest and Other Investment Income	(466)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(46)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(2,614)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 11,405		\$	30

BHF USE ONLY							
48		49		50		51	

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (2,367)	43	1
2	Expense Fixed Asset Additions under \$2,500	699	6	2
3	Miscellaneous Income Offset	(5)	21	3
4	Rental Income Offset	(941)	34	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(2,614)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

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

1		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	3	Housekeeping	\$	Progressive Housing, Inc.	100.00%	\$ 13	\$ 13	1
2	V	6	Maintenance		Progressive Housing, Inc.	100.00%	206	206	2
3	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,375	4,375	3
4	V	19	Professional Services		Progressive Housing, Inc.	100.00%	6,920	6,920	4
5	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,546	2,546	5
6	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	71,954	71,954	6
7	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	11,424	11,424	7
8	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	2,213	2,213	8
9	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	1,150	1,150	9
10	V	26	Insurance		Progressive Housing, Inc.	100.00%	464	464	10
11	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,264	2,264	11
12	V	34	Rent		Progressive Housing, Inc.	100.00%	941	941	12
13	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,212	2,212	13
14	Total			\$			\$ 106,682	\$ * 106,682	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Joshua Manor

0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace -closed	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Flossmoor	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Aviston Terrace	Aviston	& Housing	Waltonville	Workshop-closed	6
7			Park Place	Pana	Progressive Careers			7
8			Cardinal	Woodlawn	& Housing	Mt Vernon	Workshop-closed	8
9			Western Gardens	MT. Vernon	Perfection			9
10			Galaxy	Woodlawn	Cleaning	Olympia Fields	Housekeeping	10
11			Bill Goat Hill	MT. Vernon				11
12			Country Club Hill	Country Club Hills				12
13			Lee street	Country Club Hills				13
14			Baker Street	Country Club Hills				14
15			182nd Street	Country Club Hills				15
16			Osage	Park Forest				16
17			Oakwood	Park Forest				17
18			Blair	Park Forest				18
19			Lowell	Hazelcrest				19
20			Marquette	Park Forest				20
21			Cherry	Park Forest				21
22			Luella	Sauk Village				22
23			Olivia	Sauk Village				23
24			Huron	Park Forest				24
25			Wilshire	Park Forest				25
26			Constance - closed	Sauk Village				26
27			175th Place	Country Club Hills				27
28			Sauganash	Park Forest				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor # 0040345 Report Period Beginning: 7/1/2019 Ending: 5/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' PREPARATION REPORT

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.	\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3. Under or (over) accrual (line 2 minus line 1).	\$			3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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:	2015	N/A	8	
	2016	N/A	9	
	2017	N/A	10	
	2018	N/A	11	
	2019	N/A	12	
N/A - Not for profit entity				

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Joshua Manor COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040345

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	46,100	1993	\$ 20,000	1
2	Allocated from Home Office			7,369	2
3	TOTALS	46,100		\$ 27,369	3

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	\$ 275,787
5										
6										
7										
8										
	Improvement Type**									
9	Building Improvements - Smoke Detectors, & Pull Station			1994	1,590		15			1,590
10	Deluxe Barn			1994	1,684		15			1,684
11	Carpet			1997	1,055		15			1,055
12	Tile			1999	849		15			849
13	Shower			1999	2,789		15			2,789
14	Tile			2004	997		15	32	32	997
15	Bathroom Tile			2006	420		15	28	28	401
16	Kitchen Remodel			2006	1,239		15	83	83	1,133
17	Kitchen Remodel			2006	1,287		15	86	86	1,167
18	Kitchen Remodel			2006	1,955		15	130	130	1,767
19	Bedroom Remodel			2007	10,192		15	680	680	9,140
20	Bathroom Remodel			2007	695		15	46	46	590
21	Gazebo			2007	1,796		15	120	120	1,509
22	Roof Repair			2008	15,757		15	1,050	1,050	12,729
23	Roof Repair			2008	335		15	22	22	265
24	Flooring			2008	225		15	15	15	180
25	Garage Repair			2008	529		15	35	35	412
26	Building Improvements - Painting			2010	717		15	48	48	500
27	Living Room Flooring			2010	1,252		15	83	83	851
28	Living Room and Laundry Flooring			2010	797		15	53	53	543
29	Living Room and Bathroom Flooring Tile			2010	813		15	54	54	549
30	Install 5 ton condensing unit			2010	2,800		15	187	187	1,870
31	New Furnace			2012	2,100		15	140	140	1,167
32	New A/C Condesner and Coil			2012	3,600		15	240	240	1,940
33	New Sprinkler Heads			2012	1,420		15	95	95	676
34	Gutters and Extensions			2013	1,675		15	112	112	774
35	New Furnace			2013	2,275		15	152	152	1,026
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 <u>Replace Flooring Wings 2 and 4 Bedrooms and Baths</u>	<u>2019</u>	<u>3,161</u>		<u>15</u>	<u>105</u>	\$ 105	\$ 105	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47 <u>Financial Statement Depreciation</u>			<u>3,558</u>			(3,558)		47
48								48
49								49
50								50
51 <u>Allocated from Home Office</u>		<u>14,698</u>			<u>2,264</u>	2,264	<u>26,747</u>	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)		\$ 484,702	\$ 3,558		\$ 16,010	\$ 12,452	\$ 350,792	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$16,330	\$	\$1,616	\$1,616	5-10 Yrs	\$11,697	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	40,755				5-10 Yrs	40,755	73
74	Allocated from Home Office	26,514						74
75	TOTALS	\$83,599	\$	\$1,616	\$1,616		\$52,452	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2002 Chevy Venture	2016	\$1,565	\$	\$313	\$313	5	\$1,252	76
	Facility Use	2019 Dodge Caravan	2020	48,842		2,442	2,442	5	2,442	77
										78
79	Allocated from Home Office			2,944						79
80	TOTALS			\$53,351	\$	\$2,755	\$2,755		\$3,694	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$649,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$3,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$20,381	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$16,823	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$406,938	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease . N/A
N/A
9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 2,212 Description: Allocated from Home Office-Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,911		1,911	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 1,911		\$ 1,911	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 262,070	\$ 262,070	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,073)	133,716	133,716	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,321)	(3,321)	6
7	Other Prepaid Expenses	14,857	14,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	1,566	1,566	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 408,888	\$ 408,888	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,369	13
14	Buildings, at Historical Cost	3,161	484,702	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	114,587	136,950	16
17	Accumulated Depreciation (book methods)	(57,997)	(406,938)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 79,751	\$ 242,083	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 488,639	\$ 650,971	25

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (500,579)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (500,579)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	31,372	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)	\$ 31,372	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)	\$ (469,207)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Joshua Manor

0040345

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 721,302	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 721,302	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(298)	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (298)	23
	D. Non-Operating Revenue		
24	Contributions	718	24
25	Interest and Other Investment Income***	965	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,683	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Allocated from Home Office-See Pg 19B</u>	2,523	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,523	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 725,210	30

2

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

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

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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.

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SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Gain/ (Loss) on Sale of Fixed Assets	(1,335)
Miscellaneous Income	5
Rental Income	3,853
Total Line 28a	2,523

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	675	744	20,975	28.19	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,649	1,748	20,771	11.88	15
16	Dishwashers					16
17	Maintenance Workers	512	734	11,847	16.14	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	926	1,033	37,142	35.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	297	316	8,429	26.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,300	1,468	29,950	20.40	29
30	Habilitation Aides (DD Homes)	15,018	16,470	193,989	11.78	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,377	22,513	\$ 323,103 *	\$ 14.35	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

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Report Period Beginning:

7/1/2019

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Ending: 6/30/2020

Facility Name & ID Number

Joshua Manor

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Christina Durbin		Administrator	0	\$ 14,667	Workers' Compensation Insurance		\$ 18,823	IDPH License Fee		\$	
Karla Rogers		Administrator	0	22,475	Unemployment Compensation Insurance		3,059	Advertising: Employee Recruitment			
					FICA Taxes		23,170	Health Care Worker Background Check			
					Employee Health Insurance		47,341	(Indicate # of checks performed)			
					Employee Meals		4,099	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Hiring Expense		759	
					Life Insurance		638	Miscellaneous Dues & Fees		525	
					Other Employee Benefits		7,660				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 37,142							
B. Administrative - Other					Allocated from Home Office			11,424	Allocated from Home Office		2,546
Description				Amount					Less: Public Relations Expense		(46)
Allocated from Progressive Housing, Inc.				\$ 109,049					Non-allowable advertising		()
									Yellow page advertising		()
					TOTAL (agree to Schedule V,			\$ 116,214	TOTAL (agree to Sch. V,		\$ 3,784
					line 22, col.8)				line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 109,049	E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)					to Owners or Employees						
C. Professional Services					Description		Line #	Amount	Description		Amount
Vendor/Payee		Type		Amount					Out-of-State Travel		\$
Paycor		Payroll Service		\$ 4,258							
Janet Scellato		Accounting Consultant		3,781							
Wipfli		Accounting Services		437					In-State Travel		342
Hinshaw and Culburtson, LLP		Legal Services		28							
									Seminar Expense		651
									Allocated from Home Office		2,213
									Entertainment Expense		()
									(agree to Sch. V,		
									line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				\$ 8,504	TOTAL				TOTAL		\$ 3,206
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,165 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. \$ 38,630
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,099 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 100% Line 14
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT