

		FOR OHF USE				

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0036921</u></p> <p><b>Facility Name:</b> <u>STRIVE</u></p> <p><b>Address:</b> <u>415 A STREET</u> <u>PROPHETSTOWN</u> <u>61277</u>        Number City Zip Code</p> <p><b>County:</b> <u>WHITESIDE</u></p> <p><b>Telephone Number:</b> <u>815-537-5358</u> Fax # <u>815-537-2328</u></p> <p><b>IDPA ID Number:</b> <u>237136038003</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>04/09/91</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>        Name: <u>ALAN GAPINSKI</u> Telephone Number: <u>815-778-3683</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/99</u> to <u>06/30/00</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1281 747 1921 828">(Type or Print Name) <u>ALAN GAPINSKI</u></td> </tr> <tr> <td></td> <td data-bbox="1281 828 1921 885">(Title) _____</td> </tr> <tr> <td data-bbox="1144 885 1281 1039">Paid Preparer</td> <td data-bbox="1281 885 1921 941">(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td data-bbox="1281 941 1921 1006">(Print Name and Title) _____</td> </tr> <tr> <td></td> <td data-bbox="1281 1006 1921 1039">(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td data-bbox="1281 1039 1921 1130">(Telephone) ( ) Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>ALAN GAPINSKI</u>		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( ) Fax # ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
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	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) ( ) Fax # ( )																																						

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 07/01/99 Ending: 06/30/00

**III. STATISTICAL DATA**

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,611			5,611	13
14	TOTALS	5,611			5,611	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.82%

D. How many bed-hold days during this year were paid by Public Aid? 224 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 04/09/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ 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 \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/00 Fiscal Year: 06/30/00

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

STATE OF ILLINOIS

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/99 Ending: 06/30/00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	51,254	3,212	170	54,636		54,636		54,636		1
2	Food Purchase		28,091		28,091		28,091		28,091		2
3	Housekeeping	3,356	3,977		7,333		7,333		7,333		3
4	Laundry		11	21,000	21,011		21,011		21,011		4
5	Heat and Other Utilities			12,238	12,238		12,238	(901)	11,337		5
6	Maintenance	17,578	9,307	11,057	37,942	523	38,465		38,465		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	72,188	44,598	44,465	161,251	523	161,774	(901)	160,873		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	230,715	15,349	9,224	255,288	(1,403)	253,885		253,885		10
10a	Therapy			2,543	2,543		2,543		2,543		10a
11	Activities	18,781	1,980		20,761		20,761		20,761		11
12	Social Services	23,226			23,226		23,226		23,226		12
13	Nurse Aide Training					3,885	3,885		3,885		13
14	Program Transportation		2,419		2,419	(1,210)	1,209		1,209		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	272,722	19,748	11,767	304,237	1,272	305,509		305,509		16
	<b>C. General Administration</b>										
17	Administrative			93,500	93,500		93,500	(39,568)	53,932		17
18	Directors Fees										18
19	Professional Services			8,409	8,409		8,409	383	8,792		19
20	Dues, Fees, Subscriptions & Promotions			3,027	3,027		3,027	109	3,136		20
21	Clerical & General Office Expenses	22,848	4,381	19,785	47,014		47,014	782	47,796		21
22	Employee Benefits & Payroll Taxes			64,145	64,145	(3,005)	61,140	10,513	71,653		22
23	Inservice Training & Education			633	633		633		633		23
24	Travel and Seminar			3,287	3,287		3,287	427	3,714		24
25	Other Admin. Staff Transportation							285	285		25
26	Insurance-Prop.Liab.Malpractice			4,825	4,825		4,825		4,825		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	22,848	4,381	197,611	224,840	(3,005)	221,835	(27,069)	194,766		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	367,758	68,727	253,843	690,328	(1,210)	689,118	(27,970)	661,148		29

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

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

Facility Name &amp; ID Number STRIVE

#0036921

Report Period Beginning:

07/01/99

Ending:

06/30/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			20,979	20,979		20,979	6,679	27,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,821	20,821		20,821	146	20,967			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>			41,800	41,800		41,800	6,825	48,625			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					1,210	1,210		1,210			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,394	54,394		54,394		54,394			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			54,394	54,394	1,210	55,604		55,604			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	367,758	68,727	350,037	786,522		786,522	(21,145)	765,377			45

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

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning: 07/01/99

Ending: 06/30/00

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 Amount	2 Refer- ence	3 OHF 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	(901)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,738			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	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 4,837		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(25,982)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (25,982)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (21,145)		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		\$ 1,210	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 1,210		47

STRIVE ID# 0036921  
 Report Period Beginning: 07/01/99  
 Ending: 06/30/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
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75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total		0	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number STRIVE

# 0036921

Report Period Beginning:

07/01/99

Ending:

06/30/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(901)	0	0	0	0	0	0	0	0	0	0	(901)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(901)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(901)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(93,500)	35,450	18,482	0	0	0	0	0	0	0	(39,568)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	383	0	0	0	0	0	0	0	0	383	19
20	Fees, Subscriptions & Promotions	0	0	109	0	0	0	0	0	0	0	0	109	20
21	Clerical & General Office Expenses	0	0	782	0	0	0	0	0	0	0	0	782	21
22	Employee Benefits & Payroll Taxes	0	240	10,273	0	0	0	0	0	0	0	0	10,513	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	427	0	0	0	0	0	0	0	0	427	24
25	Other Admin. Staff Transportation	0	0	285	0	0	0	0	0	0	0	0	285	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>(93,260)</b>	<b>47,709</b>	<b>18,482</b>	<b>0</b>	<b>(27,069)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(901)</b>	<b>(93,260)</b>	<b>47,709</b>	<b>18,482</b>	<b>0</b>	<b>(27,970)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE# 0036921 Report Period Beginning:07/01/99 Ending:06/30/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	5,738	0	777	164	0	0	0	0	0	0	0	6,679 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	146	0	0	0	0	0	0	0	0	146 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>5,738</b>	<b>0</b>	<b>923</b>	<b>164</b>	<b>0</b>	<b>6,825 37</b>						
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>4,837</b>	<b>(93,260)</b>	<b>48,632</b>	<b>18,646</b>	<b>0</b>	<b>(21,145) 45</b>						

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES INC.	100.00%	BIG MEADOWS,INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMEN
		PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATIO
MANAGEMENT ONLY	0.00	WINNING WHEELS,INC	PROPHETSTOWN			
				LYNDON PLAY &		CHILD DAY CAR
				LEARN CENTER	LYNDON	
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILIT

**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	22 CHILD DAY CARE	\$ 4,709	LYNDON PLAY & LEARN CENTER	100.00%	\$ 4,949	\$	240
2	V	var PROFESSIONAL SERVICES	93,500	AMERICAN HEALTH ENTERPRISES,INC.	100.00%	67,278		(26,222)
3	V							
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 98,209			\$ 72,227	\$ *	(25,982)

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

Facility Name & ID Number      STRIVE      #      0036921      Report Period Beginning:      07/01/99      Ending:      06/30/00

## 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	American Health Enterprises, Inc.		Direct						\$		1
2	Alan Gapinski	President	Management								2
3	(100% owner of American He										3
4								MANAGEMENT			4
5	S.T.R.I.V.E.			0.00	7,850	5	10.00	FEES	93,500	17,3	5
6	Pleasant View			100.00	17,100	10	20.00	"	58,109	17,3	6
7	Big Meadows			100.00	22,800	14	28.00	"	121,403	17,3	7
8	Winning Wheels			0.00	29,850	18	36.00	"	153,500	17,3	8
9	Other (non-reporting)			0.00	7,477	3	6.00	"	84,000	N/A	9
10											10
11											11
12				Total	85,077						12
13								TOTAL	\$ 510,512		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

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 07/01/99

Ending: 06/30/00

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

Name of Related Organization AMERICAM HEALTH ENTERPRISES, INC  
 Street Address 501 6TH AVE. WEST  
 City / State / Zip Code LYNDON, IL 61261  
 Phone Number ( 815-778-3683  
 Fax Number ( 815-778-4503

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	DIRECT COST	1	\$ 35,450	\$ 35,450	1	\$ 35,450	1	
2	17	ADMINISTRATIVE	GROSS REVENUE	5	200,827	200,827	903,000	18,482	2	
3	19	DATA PROCESSING	GROSS REVENUE	5	4,164	0	903,000	383	3	
4	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	5	1,189	0	903,000	109	4	
5	21	SUPPLIES,PHONE	GROSS REVENUE	5	8,497	0	903,000	782	5	
6	24	TRAINING, SEMINARS	GROSS REVENUE	5	4,637	0	903,000	427	6	
7	25	ADMIN. TRANSPORTATION	GROSS REVENUE	5	3,096	0	903,000	285	7	
8	19	ACCOUNTING FEES	DIRECT COST	2	1,600	0	0	0	8	
9	30	DEPR'N. VEHICLES	GROSS REVENUE	5	8,439	0	903,000	777	9	
10	30	DEPR'N. EQUIP.	GROSS REVENUE	5	1,785	0	903,000	164	10	
11	32	INTEREST (VEHICLES)	GROSS REVENUE	5	1,582	0	903,000	146	11	
12	32	INTEREST (WORK. CAP.)	DIRECT COST	2	4,500	0	0	0	12	
13	22	BENEFITS	% OF SALARIES	377,341	5	71,875	0	53,932	10,273	13
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 347,641	\$ 236,277		\$ 67,278	25	

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	<b>IL HEALTH FACILITIES</b>						\$	\$			\$	1
2	<b>FINANCING AUTHORITIES</b>		X	<b>MORTGAGE</b>	<b>VARIES</b>	<b>11/29/90</b>	<b>381,000</b>	<b>229,000</b>	<b>08/15/10</b>	<b>6.00-7.75</b>	<b>20,821</b>	2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ <b>381,000</b>	\$ <b>229,000</b>			\$ <b>20,821</b>	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ <b>381,000</b>	\$ <b>229,000</b>			\$ <b>20,821</b>	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

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

(See instructions.)

Facility Name & ID Number **STRIVE**# **0036921** Report Period Beginning: **07/01/99** Ending: **06/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 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 2000 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 used previously to calculate a payment rate. 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 19 _____ 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:	1995 _____ 8	
	1996 _____ 9	
	1997 _____ 10	
	1998 _____ 11	
	1999 _____ 12	
		<b>FOR OFF USE ONLY</b>
		13 FROM R. E. TAX STATEMENT FOR 1999 \$
		14 PLUS APPEAL COST FROM LINE 5 \$
		15 LESS REFUND FROM LINE 6 \$
		16 AMOUNT TO USE FOR RATE CALCULATION \$

**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.**

Facility Name & ID Number STRIVE# 0036921 Report Period Beginning:07/01/99 Ending:06/30/00**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLED Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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		1991	\$ 10,207	1
2	LOCATION		1995-1997	7,113	2
3	TOTALS			\$ 17,320	3

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning:

07/01/99

Ending:

06/30/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	16		1991	1991	\$ 377,676	\$ 9,442	25	\$ 15,107	\$ 5,665	\$ 138,331	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9		MIXING VALVE		1992	1,840	46	20	92	46	808	9	
10		EMERGENCY LIGHTING		1992	723	18	10	72	54	633	10	
11		LANDSCAPING		1992	1,075	27	5		(27)	1,075	11	
12		SIDEWALK & PATIO		1993	2,578	64	40	64		523	12	
13		CARPET		1993	1,690	169	10	169		1,239	13	
14		STORAGE SHED		1994	2,920	146	20	146		1,034	14	
15		PAINTING		1997	1,625	163	10	163		582	15	
16		SIGN		1997	179	9	20	9		33	16	
17		CARPET		1997	621	62	10	62		223	17	
18		LANDSCAPING		1997	520	52	10	52		186	18	
19		CARPET		1997	4,575	458	10	458		1,640	19	
20		GARAGE		1997	1,608	80	20	80		288	20	
21		GARAGE		1998	36,165	1,447	25	1,447		4,099	21	
22		SHOWER		1998	3,322	166	20	166		415	22	
23		CARPETING		1998	1,753	351	5	351		906	23	
24		BATH ROOM TILE AND SHOWERS		2000	5,386	269	10	269		269	24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)					\$ 444,256	\$ 12,969		\$ 18,707	\$ 5,738	\$ 152,284	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.

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 87,071	\$ 6,998	\$ 6,998	\$	10-15 YRS	\$ 43,008	37
38	Current Year Purchases	12,482	1,012	1,012		5-10YRS	1,012	38
39	Fully Depreciated Assets							39
40	Home Office			164	164			40
41	TOTALS	\$ 99,553	\$ 8,010	\$ 8,174	\$ 164		\$ 44,020	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	MEDICAL APPOINTMENT	DODGE VAN 1992	1992	\$ 31,845	\$	\$	\$	5YRS	\$ 31,845	42
43	AND OUTINGS									43
44	Home Office					777	777			44
45										45
46	TOTALS			\$ 31,845	\$	\$ 777	\$ 777		\$ 31,845	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 592,974	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 20,979	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 27,658	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 6,679	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 228,149	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

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

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

**XII. RENTAL COSTS**

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

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input 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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>COMMUNITY COLLEGE      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER AIDE      <u>80</u></p>
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**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)		1,235		1,235
4	Clinical Wages (b)		2,470		2,470
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		180		180
9	<b>TOTALS</b>	\$	3,885	\$	3,885
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,885		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>4</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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	<b>TOTAL</b>			\$		\$	\$		\$		\$			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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number STRIVE

# 0036921

Report Period Beginning: 07/01/99

Ending:

06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00

(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	\$ 250	\$ 250	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (6,581) )	69,063	69,063	3
4	Supply Inventory (priced at )	9,639	9,639	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,366	1,366	6
7	Other Prepaid Expenses	17,651	17,651	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM WINNING WHEEL	1,048,359	1,048,359	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,146,328	\$ 1,146,328	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,320	17,320	13
14	Buildings, at Historical Cost	444,257	444,257	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	131,398	131,398	16
17	Accumulated Depreciation (book methods)	(175,050)	(175,050)	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): CONSTRUCTION IN PROGRE	7,060	7,060	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 424,985	\$ 424,985	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,571,313	\$ 1,571,313	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 10,896	\$ 10,896	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,118	13,118	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,704	4,704	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	REVENUE BONDS	16,000	16,000	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 44,718	\$ 44,718	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	213,000	213,000	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>	\$ 213,000	\$ 213,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 257,718	\$ 257,718	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,313,595	\$ 1,313,595	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,571,313	\$ 1,571,313	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,181,864	1
2	Restatements (describe):		2
3	JUNE 1999 NET INCOME	11,603	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,193,467	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	120,128	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)	\$ 120,128	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,313,595	24 *

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

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning: 07/01/99

Ending:

06/30/00

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 907,850	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 906,650</b>	<b>3</b>
<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>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 906,650</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	161,251	31
32	Health Care	304,237	32
33	General Administration	224,840	33
<b>B. Capital Expense</b>			
34	Ownership	41,800	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	54,394	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 786,522</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>120,128</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 120,128</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number **STRIVE**

# 0036921

Report Period Beginning: 07/01/99

Ending:

06/30/00

**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				3
4	Licensed Practical Nurses				4
5	Nurse Aides & Orderlies				5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,959	2,215	18,781	8.48
10	Activity Assistants				10
11	Social Service Workers	1,984	2,080	23,226	11.17
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	5,422	5,943	51,254	8.62
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	1,874	2,071	17,578	8.49
18	Housekeepers	378	484	3,356	6.93
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,913	2,137	22,848	10.69
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	24,374	26,199	230,715	8.81
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	37,904	41,129	\$ 367,758 *	\$ 8.94

\* 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	4	\$ 170	1/3
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	382	7,648	10/3
39	Pharmacist Consultant	12	480	10/3
40	Physical Therapy Consultant	19	902	10a/3
41	Occupational Therapy Consultant	17	758	10a/3
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	RECREATIONAL THERAPY	6	293	10a/3
48	PSYCHOLOGICAL CONSULTANT	6	590	10a/3
49	TOTAL (lines 35 - 48)	446	\$ 10,841	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			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILLINOIS HEALTH CARE ASSOC 784
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 7 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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. \_\_\_\_\_
- (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 of Public Aid during this cost report period. \$ 54,394  
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 of Public Aid, 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. \$ NONE Has any meal income been offset against related costs? NONE 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? YES  
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. \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: LINDGREN,CALLIHAN&VANOSDOL CPA'S The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.