

Facility Name & ID Number STRIVE

0036921 Report Period Beginning: 7/01/2004 Ending: 6/30/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,458			5,458
14	TOTALS	5,458			5,458

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.46%

D. How many bed-hold days during this year were paid by the Department? 260 (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)

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 4/09/1991

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: 6/30/2005 Fiscal Year: 6/30/2005

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

STATE OF ILLINOIS

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Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 7/01/2004 Ending: 6/30/2005

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	A. General Services										
1	Dietary	58,463	4,335	900	63,698		63,698		63,698		1
2	Food Purchase		32,678		32,678		32,678		32,678		2
3	Housekeeping	9,509	4,778		14,287		14,287		14,287		3
4	Laundry	943	2,371		3,314		3,314		3,314		4
5	Heat and Other Utilities			16,865	16,865		16,865	(773)	16,092		5
6	Maintenance	22,018	8,013	11,131	41,162	1,302	42,464		42,464		6
7	Other (specify):*										7
8	TOTAL General Services	90,933	52,175	28,896	172,004	1,302	173,306	(773)	172,533		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	277,449	20,966	18,692	317,107	1,393	318,500	(707)	317,793		10
10a	Therapy		60		60		60		60		10a
11	Activities	26,629	1,299		27,928		27,928		27,928		11
12	Social Services	33,067		700	33,767		33,767		33,767		12
13	CNA Training	4,080			4,080		4,080	4,000	8,080		13
14	Program Transportation		2,510		2,510		2,510		2,510		14
15	Other (specify):* DENTAL SERVICES			2,347	2,347		2,347		2,347		15
16	TOTAL Health Care and Programs	341,225	24,835	24,739	390,799	1,393	392,192	3,293	395,485		16
	C. General Administration										
17	Administrative			109,750	109,750		109,750	(31,027)	78,723		17
18	Directors Fees										18
19	Professional Services			11,251	11,251		11,251	241	11,492		19
20	Dues, Fees, Subscriptions & Promotions			3,017	3,017		3,017	(150)	2,867		20
21	Clerical & General Office Expenses	29,229	4,001	2,299	35,529		35,529	14,693	50,222		21
22	Employee Benefits & Payroll Taxes			60,265	60,265	(1,393)	58,872	16,446	75,318		22
23	Inservice Training & Education			18	18		18		18		23
24	Travel and Seminar			4,165	4,165		4,165		4,165		24
25	Other Admin. Staff Transportation							475	475		25
26	Insurance-Prop.Liab.Malpractice			11,040	11,040		11,040	132	11,172		26
27	Other (specify):*										27
28	TOTAL General Administration	29,229	4,001	201,805	235,035	(1,393)	233,642	810	234,452		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	461,387	81,011	255,440	797,838	1,302	799,140	3,330	802,470		29

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

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

Facility Name & ID Number **STRIVE**

#0036921

Report Period Beginning: 7/01/2004 Ending: 6/30/2005

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	
	D. Ownership											
30	Depreciation			44,361	44,361	(1,302)	43,059	539	43,598			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,697	15,697		15,697	193	15,890			32
33	Real Estate Taxes			3,000	3,000		3,000		3,000			33
34	Rent-Facility & Grounds			48,000	48,000		48,000		48,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			111,058	111,058	(1,302)	109,756	732	110,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,512	61,512		61,512		61,512			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			61,512	61,512		61,512		61,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	461,387	81,011	428,010	970,408		970,408	4,062	974,470			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: **7/01/2004**

Ending: **6/30/2005**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(773)	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				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	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule COMMUNITY RELATIONS	(752)	20,10		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,725)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,787		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,787		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,062		37

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

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

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

STRIVE

ID# 0036921

Report Period Beginning: 7/01/2004

Ending: 6/30/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	COMMUNITY RELATIONS	\$ (45)	20	1
2	EMPLOYEES AT OTHER SITES	(707)	10	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(752)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

7/01/2004

Ending:

6/30/2005

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)	
	A. General Services													
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	(773)	0	0	0	0	0	0	0	0	0	0	(773)	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	TOTAL General Services	(773)	0	0	0	0	0	0	0	0	0	0	(773)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(707)	0	0	0	0	0	0	0	0	0	0	(707)	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	CNA Training	0	0	0	4,000	0	0	0	0	0	0	0	4,000	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	TOTAL Health Care and Programs	(707)	0	0	4,000	0	3,293	16						
	C. General Administration													
17	Administrative	0	0	0	(31,027)	0	0	0	0	0	0	0	(31,027)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	241	0	0	0	0	0	0	0	241	19
20	Fees, Subscriptions & Promotions	(245)	0	0	95	0	0	0	0	0	0	0	(150)	20
21	Clerical & General Office Expenses	0	0	14,047	646	0	0	0	0	0	0	0	14,693	21
22	Employee Benefits & Payroll Taxes	0	708	2,465	13,273	0	0	0	0	0	0	0	16,446	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	475	0	0	0	0	0	0	0	475	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	132	0	0	0	0	0	0	0	132	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(245)	708	16,512	(16,165)	0	810	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,725)	708	16,512	(12,165)	0	3,330	29						

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%		BIG MEADOWS, INC.	SAVANNA	LYNDON PROGRESS CENTER	LYNDON	DAY TREATMENT REHABILITATION
		PLEASANT VIEW NURSING AND REHABILITATION CENTER	MORRISON	LYNDON PLAY AND LEARN CENTER	LYNDON	CHILD DAY CARE
		WINNING WHEELS, INC.	PROPHETSTOWN	FRONTIER HOLLOW APARTMENTS	PROPHETSTOWN	INDEPENDENT LIVING UNITS

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22 DAY CARE BENEFITS	\$ 2,519	LYNDON PLAY AND LEARN CENTER	100.00%	\$ 3,227	\$ 708	1
2	V	MANAGEMENT SERVICES	109,750	AMERICAN HEALTH ENTERPRISES, INC.		98,317	(11,433)	2
3	V	ADMINISTRATIVE OVERHEAD		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%	16,512	16,512	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 112,269			\$ 118,056	\$ * 5,787	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 CLERICAL SALARIES	\$	WINNING WHEELS, INC.	100.00%	\$ 14,047	\$ 14,047	15
16	V	22 BENEFITS		ADMINISTRATIVE FUND ALLOCATION		2,465	2,465	16
17	V			(SEE DETAILS, SCHEDULE VIII B, PG 8)				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		\$			\$ 16,512	\$ * 16,512	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17	MANAGEMENT FEES	\$ 109,750	AMERICAN HEALTH ENTERPRISES, INC. (SEE DETAILS - SCHEDULE VII, PAGE 8A)	0.00%	\$ 82,723	\$ (27,027)	15
16	V	19				241	241	16	
17	V	20				95	95	17	
18	V	21				646	646	18	
19	V	22				13,273	13,273	19	
20	V	24						20	
21	V	25				475	475	21	
22	V	26				132	132	22	
23	V	30				539	539	23	
24	V	32				193	193	24	
25	V							25	
26	V	17	HAB AIDE TRAINING - INSTRUCTOR FEES		RECLASS INSTRUCTIONAL PORTION	(4,000)	(4,000)	26	
27	V	13	HAB AIDE TRAINING - INSTRUCTOR FEES			4,000	4,000	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		\$ 109,750			\$ 98,317	\$ * (11,433)	39	

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 7/01/2004 Ending: 6/30/2005

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.								\$	1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT							2
3	(100 % OWNER - AHE, INC.)							MANAGEMENT		3
4								FEES		4
5	BIG MEADOWS, INC.			100.00	34,070	14	28.00	"	157,506	5
6	PLEASANT VIEW NURSING AND REHABILITAION			100.00	24,336	10	20.00	"	114,306	6
7	WINNING WHEELS, INC.				43,805	18	36.00	"	195,500	7
8	S.T.R.I.V.E.				12,170	5	10.00	"	109,750	8
9	OTHERS (NON-COST REPORTING)				7,300	3	6.00	"	136,012	9
10										10
11										11
12										12
13								TOTAL	\$ 713,074	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: 7/01/2004

Ending: 7/30/2005

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 WINNING WHEELS, INC.
 Street Address 501 6TH AVE. WEST
 City / State / Zip Code LYNDON, IL 61261
 Phone Number (815-778-3610
 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	21	ACCOUNTING SALARIES	GROSS REVENUES	6,395,084	9	\$ 92,961	\$ 966,371	\$ 14,047	1
2	22	FICA	GROSS REVENUES	6,395,084	9	6,611	966,371	999	2
3	22	WORK COMP	GROSS REVENUES	6,395,084	9	165	966,371	25	3
4	22	HEALTH INSURANCES	GROSS REVENUES	6,395,084	9	2,976	966,371	450	4
5	22	PENSION	GROSS REVENUES	6,395,084	9	1,500	966,371	227	5
6	22	DISABILITY INSURANCE	GROSS REVENUES	6,395,084	9	1,209	966,371	183	6
7	22	CHILD CARE	GROSS REVENUES	6,395,084	9	3,590	966,371	542	7
8	22	LIFE INSURANCE	GROSS REVENUES	6,395,084	9	255	966,371	39	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 109,267	\$ 92,961	\$ 16,512	25

Facility Name & ID Number STRIVE

0036921 Report Period Beginning: 7/01/2004

Ending: 7/30/2005

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 American Health Enterprises, Inc.
 Street Address 501 6th Ave. W.
 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	\$ 61,880	\$ 61,880	1	\$ 61,880	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,849,297	5	255,101	255,101	968,153	20,843
3	19	DATA PROCESSING	GROSS REVENUE	11,849,297	5	1,295	968,153	106	3
4	19	ACCOUNTING	GROSS REVENUE	11,849,297	5	1,657	968,153	135	4
5	20	DUES AND SUBSCRIPTIONS	GROSS REVENUE	11,819,297	5	1,157	968,153	95	5
6	21	SUPPLIES, PHONE	GROSS REVENUE	11,849,297	5	7,912	968,153	646	6
7	22	BENEFITS	% SALARY	536,981	5	86,162	82,723	13,273	7
8									8
9	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,849,297	5	5,810	968,153	475	9
10	26	INSURANCE	GROSS REVENUE	11,849,297	5	1,618	968,153	132	10
11	30	DEPR'N. VEHICLES	GROSS REVENUE	11,849,297	5	6,600	968,153	539	11
12	32	INTEREST VEHICLES	GROSS REVENUE	11,849,297	5	2,363	968,153	193	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 431,555	\$ 316,981		\$ 98,317	25

Facility Name & ID Number **STRIVE**# **0036921**

Report Period Beginning:

7/01/2004

Ending:

6/30/2005**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
						Amount of Note	Reporting Period Interest Expense				
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)			
YES	NO										
A. Directly Facility Related											
Long-Term											
1	IL HEALTH FACILITIES					\$	\$			\$	1
2	FINANCING AUTHORITY	X	MORTGAGE	VARIES	11/29/90	381,000	NONE	8/15/2010	6.00-7.75	10,571	2
3	IFF	X	MORTGAGE	\$3,120.00	3/2005	167,363	154,806	2/1/2010	4.5000	5,126	3
4	AMCORE BANK										4
5	HOME OFFICE ALLOCATION	X	VEHICLE	\$624.50	1/2001	30,000	6,210	10/2005	9.0000	193	5
Working Capital											
6											6
7											7
8											8
9	TOTAL Facility Related			\$3,744.50		\$ 578,363	\$ 161,016			\$ 15,890	9
B. Non-Facility Related*											
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$ 578,363	\$ 161,016			\$ 15,890	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE 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.)

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2004 report.		\$ 3,849	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.)		\$ 259	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ (3,590)	3																													
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 6,590	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.		\$ 3,000	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td></td><td>8</td></tr> <tr><td>2001</td><td></td><td>9</td></tr> <tr><td>2002</td><td>604</td><td>10</td></tr> <tr><td>2003</td><td>651</td><td>11</td></tr> <tr><td>2004</td><td>259</td><td>12</td></tr> </table>	2000		8	2001		9	2002	604	10	2003	651	11	2004	259	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2000		8																														
2001		9																														
2002	604	10																														
2003	651	11																														
2004	259	12																														
FOR OHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3610 FAX #: 815-778-4503

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of total 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-04-176-013</u>	<u>THERAPY ANNEX</u>	\$ <u>258.92</u>	\$ <u>258.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>258.92</u>	\$ <u>258.92</u>

B. Real Estate Tax Cost Allocation:

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 X NO

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/01/2004

Ending:

6/30/2005

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLER Number of Stories ONEC. 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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/GARAGE/PARKING		1991	\$ 10,207	1
2			1995-2002	21,744	2
3	TOTALS			\$ 31,951	3

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/01/2004

Ending:

6/30/2005

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		
Bed* 16	FOR OHF USE ONLY	Year Acquired 1991	Year Constructed 1991	Cost \$ 377,675	Current Book Depreciation \$ 9,442	Life in Years 40	Straight Line Depreciation \$ 9,442	Adjustments \$	Accumulated Depreciation \$ 134,132	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	SIDEWALK AND PATIO		1992	2,578	64		64		845	9
10	CARPET		1992	1,690					1,690	10
11	EMERGENCY LIGHTING		1992	723	18		18		254	11
12	MIXING VALVES		1992	1,840	46		46		648	12
13	LANDSCAPING		1992	1,075	27		27		379	13
14	STORAGE SHED		1993	2,920	146		146		1,764	14
15	ROADWAY		1995	2,556	183		183		731	15
16	SIGN		1996	180	9		9		78	16
17	PAINTING		1996	1,625	163		163		1,395	17
18	CARPETING		1997	621	62		62		533	18
19	LANDSCAPING		1997	520	52		52		446	19
20	CARPET		1997	4,575	457		457		3,927	20
21	GARAGE		1997	1,608	80		80		690	21
22	GARAGE		1997	36,165	1,447		1,447		11,332	22
23	SHOWERS		1998	3,322	166		166		1,246	23
24	CARPET		1998	1,753					1,753	24
25	BATHROOM TILE AND SHOWERS		1999	5,386	539		539		2,963	25
26	SIDEWALKS		2000	1,113	56		56		274	26
27	PARKING LOT		2000	4,972	497		497		2,320	27
28	FRONT HALLWAY REMODELING		2001	5,817	291		291		1,042	28
29	STEPS AND SIDEWALKS TO PARKING LOT		2002	4,770	238		238		794	29
30	REMODEL LOUNGE, ENTRY AND NURSE STATION		2002	46,157	2,307		2,307		6,923	30
31	RESIDENT ROOM CARPETING		2002	3,982	569		569		1,422	31
32	SIDEWALKS		2001	13,544	347		347		1,307	32
33	LANDSCAPING		2001	8,745	875		875		3,061	33
34	STEPS		2001	1,150	29		29		108	34
35	DRAINAGE & GRADING		2001	4,794	240		240		859	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/01/2004

Ending:

6/30/2005

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	SLIDING POWER DOORS	2001	\$ 4,274	\$ 214		\$ 214	\$	\$ 766	37
38	LEASEHOLD IMPROVEMENTS	2001	20,083	515		515		1,802	38
39	WINDOW TREATMENTS	2001	3,629	518		518		1,814	39
40	CARPETING	2001	14,041	2,006		2,006		7,021	40
41	FENCING	2001	1,334	89		89		274	41
42	LIFT STATION AND GRINDER	2005	4,270	24		24		24	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 589,487	\$ 21,716		\$ 21,716	\$	\$ 194,617	70

**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	
71	Purchased in Prior Years	\$ 138,798	\$ 15,080	\$ 15,080	\$	VAR	\$ 102,700	71
72	Current Year Purchases	12,032	876	876		7	876	72
73	Fully Depreciated Assets	9,020				7	9,020	73
74								74
75	TOTALS	\$ 159,850	\$ 15,956	\$ 15,956	\$		\$ 112,596	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	\$ 53,867	\$ 5,387	\$ 5,387		5	\$ 5,387	76
77										77
78	HOME OFFICE VEHICLE ALLOCATION					539	539			78
79										79
80	TOTALS			\$ 53,867	\$ 5,387	\$ 5,926	\$ 539		\$ 5,387	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 835,155 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,059 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,598 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 539 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 312,600 85

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

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

G. Construction-in-Progress

	Description	Cost	
92	ENVIRONMENTAL STUDY	\$ 2,708	92
93			93
94			94
95		\$ 2,708	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JAMES BIRKLEBAW

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	<u>THERAPY ANNEX</u>						5
6		<u>2001</u>	<u>NONE</u>	<u>12/2001</u>	<u>48,000</u>	<u>5</u>	<u>N/A</u>
7	TOTAL			\$ 48,000			7

10. Effective dates of current rental agreement:

Beginning 12/2001
 Ending 11/2006

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

Fiscal Year Ending Annual Rent

12.	<u>/2006</u>	\$ <u>48,000</u>
13.	<u>/2007</u>	\$ <u>20,000</u>
14.	<u>/2008</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	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.

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? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>40</u>	

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)		1,360		1,360
4 Clinical Wages (b)		2,720		2,720
5 In-House Trainer Wages (c)			4,000	4,000
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$	\$ 4,080	\$ 4,000	\$ 8,080
10 SUM OF line 9, col. 1 and 2 (e)	\$	4,080		

- (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.

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

	Service	1 Schedule V Line & Column Reference	2		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 prescripts											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	TOTAL			\$		\$		\$		\$			\$	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.

STATE OF ILLINOIS

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Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 7/01/2004

Ending:

6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2005

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 250	\$ 364,471	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 13689/118726)	147,152	1,161,594	3
4	Supply Inventory (priced at COST)	8,232	51,883	4
5	Short-Term Investments		2,693,240	5
6	Prepaid Insurance	3,767	22,981	6
7	Other Prepaid Expenses	18,713	36,390	7
8	Accounts Receivable (owners or related parties)		1,049,319	8
9	Other(specify): RENT DEPOSIT	8,000	689,836	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 186,113	\$ 6,069,714	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		4,298	12
13	Land	31,951	282,861	13
14	Buildings, at Historical Cost	546,126	7,704,019	14
15	Leasehold Improvements, at Historical Cost	43,361	151,205	15
16	Equipment, at Historical Cost	213,718	2,210,903	16
17	Accumulated Depreciation (book methods)	(312,600)	(4,396,778)	17
18	Deferred Charges	2,258	3,691	18
19	Organization & Pre-Operating Costs		22,848	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRE	2,708	54,943	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 527,522	\$ 6,015,142	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 713,635	\$ 12,084,856	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 24,662	\$ 265,247	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	30,535	212,625	29
30	Accrued Salaries Payable	35,522	254,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,835	12,964	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,590	6,590	32
33	Accrued Interest Payable		1,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>DUE TO OTHER FUNDS</u>		1,049,319	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 99,145	\$ 1,802,506	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	124,271	1,847,901	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>PA ADVANCE FOR DAY TREATMENT</u>		49,028	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 124,271	\$ 1,896,929	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 223,416	\$ 3,699,435	46
47	TOTAL EQUITY(page 18, line 24)	\$ 490,219	\$ 8,385,421	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 713,635	\$ 12,084,856	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 524,235	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 524,235	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	57,475	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) ROUNDING	4	15
16	Other (describe) INTERCOMPANY TRANSFERS	(91,495)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (34,016)	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)	\$ 490,219	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 7/01/2004

Ending:

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6/30/2005

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,025,196	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,023,996	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	1,421	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)	\$ 1,421	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	1,759	28
28a	AIDES AT OTHER SITES	707	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,466	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,027,883	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	172,004	31
32	Health Care	390,799	32
33	General Administration	235,035	33
B. Capital Expense			
34	Ownership	111,058	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	61,512	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 970,408	40
41	Income before Income Taxes (line 30 minus line 40)**	57,475	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,475	43

* 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:

7/01/2004

Ending:

6/30/2005

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			\$	\$	1
2					2
3					3
4					4
5					5
6	480	480	4,080	8.50	6
7					7
8					8
9	2,055	2,186	26,629	12.18	9
10					10
11	2,012	2,120	33,067	15.60	11
12					12
13					13
14	5,511	6,027	58,463	9.70	14
15					15
16					16
17	1,917	2,119	22,018	10.39	17
18	1,227	1,330	9,509	7.15	18
19	122	132	943	7.14	19
20					20
21					21
22					22
23	1,947	2,188	29,229	13.36	23
24					24
25					25
26					26
27					27
28					28
29					29
30	24,342	26,564	277,449	10.44	30
31					31
32					32
33					33
34	39,613	43,146	\$ 461,387 *	\$ 10.69	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	20	\$ 900	1,3	35
36	24	3,000	9,3	36
37				37
38	417	9,950	10,3	38
39	11	420	10,3	39
40				40
41				41
42				42
43				43
44				44
45				45
46	24	2,347	15,3	46
47	7	700	12,3	47
48	1	40	10,3	48
49	504	\$ 17,357		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51	257	5,473	10,3	51
52	229	2,809	10,3	52
53	486	\$ 8,282		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting	\$ 1,206	5	\$ 121	\$ 241	\$ 241	\$ 241	\$ 241	\$ 121			
2		3,040	5	304	608	608	608	608	304			
3		742	5	74	149	149	149	149	72			
4		1,523	5		152	304	304	304	304	155		
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$ 6,511		\$ 499	\$ 1,150	\$ 1,302	\$ 1,302	\$ 1,302	\$ 801	\$ 155		\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA / 830
- (3) Did the nursing home make political contributions or payments to a political 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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 630 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 during this cost report period. \$ 61,512
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? YES/ACTUAL H 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 benefit: on Schedule V. \$ NONE Has any meal income been offset against related costs? NONE Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NONE
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
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? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (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.