

Facility Name & ID Number STRIVE# 0036921 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,642</u>			<u>5,642</u>
14	TOTALS	<u>5,642</u>			<u>5,642</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

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

198 (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 4/9/91

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

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	
	A. General Services											
1	Dietary	61,347	6,149	1,080	68,576		68,576		68,576			1
2	Food Purchase		35,941		35,941		35,941		35,941			2
3	Housekeeping	7,259	4,393		11,652		11,652		11,652			3
4	Laundry	2,905	1,357		4,262		4,262		4,262			4
5	Heat and Other Utilities			18,263	18,263		18,263	(1,381)	16,882			5
6	Maintenance	23,375	6,889	13,221	43,485	1,302	44,787		44,787			6
7	Other (specify):*											7
8	TOTAL General Services	94,886	54,729	32,564	182,179	1,302	183,481	(1,381)	182,100			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	289,073	24,543	31,385	345,001	(865)	344,136		344,136			10
10a	Therapy			450	450		450		450			10a
11	Activities	27,499	3,607		31,106		31,106		31,106			11
12	Social Services	34,204			34,204		34,204		34,204			12
13	CNA Training					3,060	3,060	4,000	7,060			13
14	Program Transportation		3,507		3,507		3,507		3,507			14
15	Other (specify):* DENTAL SERVICES			2,347	2,347		2,347		2,347			15
16	TOTAL Health Care and Programs	350,776	31,657	37,182	419,615	2,195	421,810	4,000	425,810			16
	C. General Administration											
17	Administrative			112,750	112,750		112,750	(43,031)	69,719			17
18	Directors Fees											18
19	Professional Services			11,826	11,826		11,826	105	11,931			19
20	Dues, Fees, Subscriptions & Promotions			3,074	3,074		3,074	(461)	2,613			20
21	Clerical & General Office Expenses	28,658	5,465	4,391	38,514		38,514	15,300	53,814			21
22	Employee Benefits & Payroll Taxes			66,358	66,358	(2,195)	64,163	1,000	65,163			22
23	Inservice Training & Education			241	241		241		241			23
24	Travel and Seminar			4,867	4,867		4,867	11,075	15,942			24
25	Other Admin. Staff Transportation							544	544			25
26	Insurance-Prop.Liab.Malpractice			6,440	6,440		6,440	176	6,616			26
27	Other (specify):*											27
28	TOTAL General Administration	28,658	5,465	209,947	244,070	(2,195)	241,875	(15,292)	226,583			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	474,320	91,851	279,693	845,864	1,302	847,166	(12,673)	834,493			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.

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#0036921

Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			50,335	50,335	(1,302)	49,033	393	49,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,847	9,847		9,847	109	9,956			32
33	Real Estate Taxes											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			108,182	108,182	(1,302)	106,880	502	107,382			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			63,803	63,803		63,803		63,803			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,803	63,803		63,803		63,803			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	474,320	91,851	451,678	1,017,849		1,017,849	(12,171)	1,005,678			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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(1,381)	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				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	(262)	20		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		20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,643)		\$	30

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

		1	2	
		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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,643)		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

BHF USE ONLY						
48		49		50		51
						52

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Sch. V Line
Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	COMMUNITY RELATIONS	\$ (204)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(204)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	(1,381)	0	0	0	0	0	0	0	0	0	0	(1,381)	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	(1,381)	0	0	0	0	0	0	0	0	0	0	(1,381)	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	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	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	0	0	0	4,000	0	4,000	16						
	C. General Administration													
17	Administrative	0	0	0	(43,031)	0	0	0	0	0	0	0	(43,031)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	105	0	0	0	0	0	0	0	105	19
20	Fees, Subscriptions & Promotions	(466)	0	0	5	0	0	0	0	0	0	0	(461)	20
21	Clerical & General Office Expenses	0	0	15,232	68	0	0	0	0	0	0	0	15,300	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,000	0	0	0	0	0	0	0	1,000	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	11,075	0	0	0	0	0	0	0	11,075	24
25	Other Admin. Staff Transportation	0	0	0	544	0	0	0	0	0	0	0	544	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	176	0	0	0	0	0	0	0	176	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(466)	0	15,232	(30,058)	0	(15,292)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,847)	0	15,232	(26,058)	0	(12,673)	29						

STATE OF ILLINOIS

Facility Name & ID Number STRIVE

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Ending:

Summary B

6/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	393	0	0	0	0	0	0	0	393	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	109	0	0	0	0	0	0	0	109	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	TOTAL Ownership	0	0	0	502	0	502	37						
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,847)	0	15,232	(25,556)	0	(12,171)	45						

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VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES, INC	100%	BIG MEADOWS, INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
		PLEASANT VIEW NURSING & REHABILITATION MORRISON		CENTER	LYNDON	REHABILITATION
		WINNING WHEELS, INC.	PROPHETSTOWN	LYNDON PLAY &		
				LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

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 DAYCARE BENEFITS	\$ 331	LYNDON PLAY & LEARN CENTER	100.00%	\$ 331	\$	1
2	V	MANAGEMENT SERVICES	112,750	AMERICAN HEALTH ENTERPRISES, INC.		87,194	(25,556)	2
3	V	ADMINISTRATION OVERHEAD		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%	17,786	17,786	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		\$ 113,081			\$ 105,311	\$ * (7,770)	14

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

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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	\$	Wiining Wheels inc	100.00%	\$ 15,232	\$ 15,232	15
16	V				Admin Fund llocation		2,554	2,554	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 17,786	\$ * 17,786	39

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

Facility Name & ID Number STRIVE# 0036921Report Period Beginning: 7/1/05Ending: 6/30/06**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	\$ 112,750	AMERICAN HEALTH ENTERPRISES, INC.	0.00%	\$ 73,719	\$ (39,031)	15
16	V	19		(SEE DETAILS - SCHEDULE VII, PAGE 8A)		105	105	16
17	V	20				5	5	17
18	V	21				68	68	18
19	V	22				1,000	1,000	19
20	V	24				11,075	11,075	20
21	V	25				544	544	21
22	V	26				176	176	22
23	V	30				393	393	23
24	V	32				109	109	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		\$ 112,750			\$ 87,194	\$ * (25,556)	39

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

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STRIVE

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	American health Enterprises								\$	1
2	ALAN Gapinski	President								2
3	100% owner AHE									3
4										4
5	Big meadows			100.00		14	28.00	management Fee:	162,563	5
6	Pleasant View			100.00		10	20.00	management Fee:	116,983	6
7	Winning Wheels					18	36.00	management Fee:	201,500	7
8	STRIVE					5	10.00	management Fee:	112,750	8
9	Others Non Cost reporting					3	6.00	management Fee:	139,750	9
10										10
11										11
12										12
13								TOTAL	\$ 733,546	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: 7/1/05

Ending: 6/30/06

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 (815-778-3683
 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	21	ACCOUNTING SALARIES	GROSS REVENUES	6,388,807	9	\$ 96,513	\$ 96,513	1,008,315	\$ 15,232	1
2	22	FICA	GROSS REVENUES	6,388,807	9	7,194	1,008,315	1,135		2
3	22	WORK COMP	GROSS REVENUES	6,388,807	9	292	1,008,315	46		3
4	22	HEALTH INSURANCE	GROSS REVENUES	6,388,807	9	1,824	1,008,315	288		4
5	22	PENSION	GROSS REVENUES	6,388,807	9	1,500	1,008,315	237		5
6	22	DISABILITY INSURANCE	GROSS REVENUES	6,388,807	9	1,171	1,008,315	185		6
7	22	CHILD CARE	GROSS REVENUES	6,388,807	9	3,942	1,008,315	622		7
8	22	LIFE INSURANCE	GROSS REVENUES	6,388,807	9	257	1,008,315	41		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					\$ 112,693	\$ 96,513		\$ 17,786	25

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 7/1/05

Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization AMERICAN 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

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	1	\$ 57,074	\$ 57,074	1	\$ 57,074	1
2	17	ADMINISTRATIVE	GROSS REVENUE	12,046,542	5	207,409	207,409	966,731	16,645	2
3	19	DATA PROCESSING	GROSS REVENUE	12,046,542	5	1,311		966,731	105	3
4	19	ACCOUNTING	GROSS REVENUE	12,046,542	5	68		966,731	5	4
5	20	DUES & SUBSCRIPTIONS	GROSS REVENUE	12,046,542	5	851		966,731	68	5
6	21	SUPPLIES, PHONE	GROSS REVENUE	12,046,542	5	12,462		966,731	1,000	6
7	22	BENEFITS	% SALARY	454,180	5	68,329		73,612	11,075	7
8	25	ADMIN. TRANSPORTATION	GROSS REVENUE	12,046,542	5	6,782		966,731	544	8
9	26	INSURANCE	GROSS REVENUE	12,046,542	5	2,199		966,731	176	9
10	30	DEPR. VEHICLES	GROSS REVENUE	12,046,542	5	4,895		966,731	393	10
11	32	INTEREST VEHICLES	GROSS REVENUE	12,046,542	5	1,358		966,731	109	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					\$ 362,738	\$ 264,483		\$ 87,194	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	IFF		X	MORTGAGE	\$3,120.15	3/2005	\$ 167,363	\$ 126,341	2/1/2010	4.5000	\$ 9,847	1								
2												2								
3	AMCORE BANK											3								
4	HOME OFFICE ALLOCATION		X	VEHICLE	\$624.50	1/2001	30,000		10/2005	9.0000	109	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,744.65		\$ 197,363	\$ 126,341			\$ 9,956	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 197,363	\$ 126,341			\$ 9,956	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

Facility Name & ID Number **STRIVE**

0036921 Report Period Beginning: **7/1/05**

Ending: **6/30/06**

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 2005 report.		\$ 6,590	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).		\$ (6,590)	3																													
4. Real Estate Tax accrual used for 2006 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.			7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td></td><td>8</td></tr> <tr><td>2002</td><td>604</td><td>9</td></tr> <tr><td>2003</td><td>651</td><td>10</td></tr> <tr><td>2004</td><td>259</td><td>11</td></tr> <tr><td>2005</td><td></td><td>12</td></tr> </table>	2001		8	2002	604	9	2003	651	10	2004	259	11	2005		12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</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 BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001		8																														
2002	604	9																														
2003	651	10																														
2004	259	11																														
2005		12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number STRIVE

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLER Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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			1995-2006	41,744	2
3	TOTALS			\$ 51,951	3

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	\$ 377,675	\$ 9,442	40	\$ 9,442	\$	\$ 143,574	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SIDEWALK & PATIO		1992	2,578	64	40	64		909	9
10		CARPET		1992	1,690		10			1,690	10
11		EMERGENCY LIGHTING		1992	723	18	40	18		272	11
12		MIXING VALUES		1992	1,840	46	40	46		694	12
13		LANDSCAPING		1992	1,075	27	40	27		406	13
14		STORAGE SHED		1993	2,920	146	20	146		1,910	14
15		ROADWAY		1995	2,556	183	14	183		913	15
16		SIGN		1996	179	9	20	9		86	16
17		PAINTING		1996	1,625	81	10	81		1,476	17
18		CARPET		1997	621	31	10	31		564	18
19		LANDSCAPING		1997	520	26	10	26		472	19
20		CARPET		1997	4,575	229	10	229		4,156	20
21		GARAGE		1997	1,608	80	20	80		770	21
22		GARAGE		1997	36,165	1,447	25	1,447		12,778	22
23		SHOWERS		1998	3,322	166	20	166		1,412	23
24		CARPET		1998	1,753		5			1,753	24
25		BATHROOM TILE & SHOWER		1999	5,386	539	10	539		3,501	25
26		SIDEWALK		2000	1,113	56	20	56		329	26
27		PARKING LOT		2000	4,972	497	10	497		2,818	27
28		FRONT WALKWAY		2001	5,817	291	20	291		1,333	28
29		STEPS & SIDEWALKS TO PARKING LOT		2002	4,770	238	20	238		1,033	29
30		ROMODEL LOUNGE, ENTRY, & NURSE STATION		2002	46,157	2,308	20	2,308		9,231	30
31		RESIDENT ROOMS CARPET		2002	3,982	569	7	569		1,991	31
32		LIFT STATION & GRINDER		2005	4,270	285	15	285		308	32
33		SIDEWALKS		2001	13,544	347	39	347		1,654	33
34		LANDSCAPING		2001	8,745	875	10	875		3,935	34
35		STEPS		2001	1,150	29	39	29		138	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

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	DRAINAGE & GRADING	2001	\$ 4,794	\$ 1,491	20	\$ 240	\$	\$ 1,099	37
38	SLIDING POWER DOOR	2001	4,274	214	20	214		979	38
39	LEASEHOLD IMPROVEMENTS	2001	20,083	515	39	515		2,317	39
40	WINDOW TREATMENT	2001	3,629	518	7	518		2,333	40
41	CARPET	2001	14,041	2,006	7	2,006		9,026	41
42	FENCING	2001	1,334	89	15	89		363	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	\$ 22,861		\$ 21,610	\$	\$ 216,227	70

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	\$ 144,102	\$ 15,845	\$ 15,845	\$ (0)	VARIOUS	\$ 112,804	71
72	Current Year Purchases	9,307	804	804	0	7	804	72
73	Fully Depreciated Assets	9,194				VARIOUS	9,194	73
74								74
75	TOTALS	\$ 162,603	\$ 16,649	\$ 16,649	\$ 0		\$ 122,802	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	\$ 10,773	\$ 10,773	\$	5	\$ 16,160	76
77										77
78	HOME OFFICE VEHICLE ALLOCATION					393	393			78
79										79
80	TOTALS			\$ 53,867	\$ 10,773	\$ 11,166	\$ 393		\$ 16,160	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 857,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 50,284	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 49,426	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (858)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 355,189	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	\$ 2,828	92
93			93
94			94
95		\$ 2,828	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.

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 7/1/05

Ending: 6/30/06

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>	6
7	TOTAL				\$ <u>48,000</u>			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>/2007</u>	\$ <u>20,000</u>
13.	<u>/2008</u>	\$
14.	<u>/2009</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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. <u>CLASSROOM PORTION:</u></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 CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,020		1,020
4	Clinical Wages (b)		2,040		2,040
5	In-House Trainer Wages (c)			4,000	4,000
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,060	\$ 4,000	\$ 7,060
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,060		

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# 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.

Facility Name & ID Number STRIVE# 0036921Report Period Beginning: 7/1/05

Ending:

6/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/06

(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	\$ 363,170	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>171051/14889</u>)	156,162	1,388,929	3
4	Supply Inventory (priced at <u>COST</u>)	6,270	49,563	4
5	Short-Term Investments		2,232,901	5
6	Prepaid Insurance	3,273	19,967	6
7	Other Prepaid Expenses	17,281	27,429	7
8	Accounts Receivable (owners or related parties)	25,605	1,225,300	8
9	Other(specify): <u>RENT DEPOSIT</u>	8,000	717,439	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 216,841	\$ 6,024,698	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		3,266	12
13	Land	51,951	302,861	13
14	Buildings, at Historical Cost	546,126	7,806,559	14
15	Leasehold Improvements, at Historical Cost	43,361	151,205	15
16	Equipment, at Historical Cost	216,470	2,176,153	16
17	Accumulated Depreciation (book methods)	(355,189)	(4,613,686)	17
18	Deferred Charges	956	2,070	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): <u>CONSTRUCTION IN PROGRE</u>	2,828	23,878	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 506,502	\$ 5,852,306	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 723,343	\$ 11,877,004	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 20,245	\$ 134,475	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	32,420	112,842	29
30	Accrued Salaries Payable	20,736	141,707	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,075	38,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,457	6,457	32
33	Accrued Interest Payable		1,991	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>DUE TO OTHER FUNDS</u>		1,225,300	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 84,933	\$ 1,660,794	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	93,921	1,736,772	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)	\$ 93,921	\$ 1,785,800	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 178,854	\$ 3,446,594	46
47	TOTAL EQUITY(page 18, line 24)	\$ 544,488	\$ 8,430,410	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 723,343	\$ 11,877,004	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 490,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 490,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 54,269	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)	\$ 54,269	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)	\$ 544,488	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	\$ 1,067,436	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,066,236	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	4,573	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)	\$ 4,573	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	1,421	28
28a	LOSS ON DISPOSAL OF EQUIPMENT	(112)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,310	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,072,119	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	474,320	31
32	Health Care	91,851	32
33	General Administration	279,693	33
B. Capital Expense			
34	Ownership	108,182	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	63,803	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,017,849	40
41	Income before Income Taxes (line 30 minus line 40)**	54,269	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 54,269	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: 7/1/05

Ending: 6/30/06

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	CNAs & Orderlies				5	
6	CNA Trainees				6	
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director	2,012	2,170	27,499	12.67	9
10	Activity Assistants					10
11	Social Service Workers	1,935	2,115	34,204	16.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,425	5,871	61,347	10.45	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,976	2,162	23,375	10.81	17
18	Housekeepers	847	888	7,259	8.17	18
19	Laundry	340	356	2,905	8.16	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,879	2,078	28,658	13.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,080	27,452	289,073	10.53	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	39,494	43,092	\$ 474,320 *	\$ 11.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	24	\$ 1,080	1,3	35
36	Medical Director	24	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	384	11,000	10,3	38
39	Pharmacist Consultant	12	480	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>DENTAL SERVICES</u>	24	2,347	15,3	46
47	<u>PSYCHOLOGICAL</u>	5	450	12,3	47
48					48
49	TOTAL (lines 35 - 48)	473	\$ 18,357		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	516	11,445	10,3	51
52	Certified Nurse Assistants/Aides	722	8,461	10,3	52
53	TOTAL (lines 50 - 52)	1,238	\$ 19,906		53

Facility Name & ID Number STRIVE

Report Period Beginning: 7/1/05

Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	PAINTING	7/01	\$ 1,206	5	\$ 241	\$ 241	\$ 241	\$ 241	\$ 121	\$	\$	\$	
2	PAINTING	9/01	3,040	5	608	608	608	608	304				
3	PAINTING	6/02	742	5	149	149	149	149	72				
4	PAINTING	8/02	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		\$ 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. ILLINOIS HEALTH CARE ASSOC.-\$839
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 547 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. \$ 63,803
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 benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
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, VAN OSDOL, 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? NO If no, please explain. NOT AVAILABLE YET
- (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? NO
Attach invoices and a summary of services for all architect and appraisal fees.