



Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 7/1/07 Ending: 6/30/08

**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>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</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>5,856</u>			<u>5,856</u>
14	TOTALS	<u>5,856</u>			<u>5,856</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 100.00%

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

124 (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: 6/30/08 Fiscal Year: 6/30/08

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	68,811	4,816	1,050	74,677		74,677		74,677		1
2	Food Purchase		38,034		38,034		38,034		38,034		2
3	Housekeeping	7,386	3,226		10,612		10,612		10,612		3
4	Laundry	3,083	1,413		4,496		4,496		4,496		4
5	Heat and Other Utilities			19,896	19,896		19,896	(1,353)	18,543		5
6	Maintenance	25,839	12,904	6,705	45,448	155	45,603		45,603		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	105,119	60,393	27,651	193,163	155	193,318	(1,353)	191,965		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	320,075	27,055	25,395	372,525	(2,160)	370,365		370,365		10
10a	Therapy										10a
11	Activities	28,716	3,399		32,115		32,115		32,115		11
12	Social Services	35,608			35,608		35,608		35,608		12
13	CNA Training					2,160	2,160		2,160		13
14	Program Transportation		4,064		4,064		4,064		4,064		14
15	Other (specify):* <b>DENTAL SERVICES</b>			2,340	2,340		2,340		2,340		15
16	<b>TOTAL Health Care and Programs</b>	384,399	34,518	30,735	449,652		449,652		449,652		16
	<b>C. General Administration</b>										
17	Administrative			118,750	118,750		118,750		118,750		17
18	Directors Fees										18
19	Professional Services			10,980	10,980		10,980		10,980		19
20	Dues, Fees, Subscriptions & Promotions			3,491	3,491		3,491		3,491		20
21	Clerical & General Office Expenses	30,738	9,978	3,695	44,411		44,411		44,411		21
22	Employee Benefits & Payroll Taxes			80,450	80,450		80,450		80,450		22
23	Inservice Training & Education			23	23		23		23		23
24	Travel and Seminar			7,100	7,100		7,100		7,100		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,356	4,356		4,356		4,356		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	30,738	9,978	228,845	269,561		269,561		269,561		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	520,256	104,889	287,231	912,376	155	912,531	(1,353)	911,178		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.

STRIVE  
415 A Street  
Prophetstown, IL 61277  
IDPH #0036921

FYE08

Line #	(1)	DR.	CR.	Cost Report Line Line #
10	Nursing & Medical Records	2,160		10
13	CNA Training		2,160	13

Reclassify Wages

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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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			52,526	52,526	(155)	52,371	52,371			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			7,524	7,524		7,524	7,524			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			60,050	60,050	(155)	59,895	59,895			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			63,094	63,094		63,094	63,094			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			63,094	63,094		63,094	63,094			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	520,256	104,889	410,375	1,035,520		1,035,520	(1,353)	1,034,167		45

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

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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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,353)			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				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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,353)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,353)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49





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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
		BIG MEADOWS, INC	SAVANNA	LYNDON PROGRESS CENTER	LYNDON	DAY TREATMENT REHABILITATION
		WINNING WHEELS, INC.	PROPHETSTOWN	LYNDON PLAY & LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW APARTMENTS	PROPHETSTOWN	INDEPENDENT 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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

\* 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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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.

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**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	IFF		X	MORTGAGE	\$3,120.15	3/2005	\$ 167,363	\$ 60,012	2/1/2010	4.5000	\$ 7,524	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$3,120.15		\$ 167,363	\$ 60,012			\$ 7,524	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 167,363	\$ 60,012			\$ 7,524	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>PT SE NW SEC 4 TWP 19 RNG 5 MF</u>	\$ <u>282.00</u>	\$ <u>282.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>282.00</u>	\$ <u>282.00</u>

**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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

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**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).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY/GARAGE/PARKING</u>		<u>1991</u>	<u>\$ 10,207</u>	1
2			<u>1995-2007</u>	<u>58,774</u>	2
3	<b>TOTALS</b>			<b>\$ 68,981</b>	3

Facility Name &amp; ID Number STRIVE

**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	\$	\$ 162,458	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		SIDEWALK & PATIO		1992	2,578	64	40	64		1,038	9
10		CARPET		1992	1,690		10			1,690	10
11		EMERGENCY LIGHTING		1992	723	18	40	18		308	11
12		MIXING VALUES		1992	1,840	46	40	46		786	12
13		LANDSCAPING		1992	1,075	27	40	27		460	13
14		STORAGE SHED		1993	2,920	146	20	146		2,202	14
15		ROADWAY		1995	2,556	183	14	183		1,278	15
16		SIGN		1996	179	9	20	9		104	16
17		PAINTING		1996	1,625		10			1,625	17
18		CARPET		1997	621		10			621	18
19		LANDSCAPING		1997	520		10			520	19
20		CARPET		1997	4,575		10			4,575	20
21		GARAGE		1997	1,608	80	20	80		931	21
22		GARAGE		1997	36,165	1,447	25	1,447		15,671	22
23		SHOWERS		1998	3,322	166	20	166		1,744	23
24		CARPET		1998	1,753		5			1,753	24
25		BATHROOM TILE & SHOWER		1999	5,386	539	10	539		4,578	25
26		SIDEWALK		2000	1,113	56	20	56		441	26
27		PARKING LOT		2000	4,972	497	10	497		3,812	27
28		FRONT WALKWAY		2001	5,817	291	20	291		1,915	28
29		STEPS & SIDEWALKS TO PARKING LOT		2002	4,770	238	20	238		1,510	29
30		ROMODEL LOUNGE, ENTRY, & NURSE STATION		2002	46,157	2,308	20	2,308		13,847	30
31		RESIDENT ROOMS CARPET		2002	3,982	569	7	569		3,129	31
32		LIFT STATION & GRINDER		2005	4,270	285	15	285		878	32
33		HALL & OFFICE CARPET		2006	4,391	627	7	627	(0)	941	33
34		THERAPY ANNEX		2006	173,000	5,767	30	5,767	0	9,131	34
35		SIDEWALKS		2001	13,544	347	39	347		2,349	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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPING	2001	\$ 8,745	\$ 875	10	\$ 875	\$	\$ 5,684	37
38	STEPS	2001	1,150	29	39	29		197	38
39	DRAINAGE & GRADING	2001	4,794	240	20	240		1,578	39
40	SLIDING POWER DOOR	2001	4,274	214	20	214		1,407	40
41	LEASEHOLD IMPROVEMENTS	2001	20,083	515	39	515		3,347	41
42	WINDOW TREATMENT	2001	3,629	518	7	518		3,370	42
43	CARPET	2001	14,041	2,006	7	2,006		13,038	43
44	FENCING	2001	1,334	89	15	89		541	44
45	CARPET	2008	928	66	7	66	(0)	66	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)		\$ 767,806	\$ 27,703		\$ 27,703	\$ (0)	\$ 269,524	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: 7/1/07 Ending: 6/30/08

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	\$ 111,432	\$ 13,532	\$ 13,532	\$	VARIOUS	\$ 78,409	71
72	Current Year Purchases	5,113	365	365		7	365	72
73	Fully Depreciated Assets	70,298				VARIOUS	70,298	73
74								74
75	TOTALS	\$ 186,843	\$ 13,897	\$ 13,897	\$		\$ 149,072	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	\$ 37,707	76
77										77
78										78
79										79
80	TOTALS			\$ 53,867	\$ 10,773	\$ 10,773	\$		\$ 37,707	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)	\$ 1,077,497	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,371	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 52,371	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 456,303	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	\$ 3,578	92
93			93
94			94
95		\$ 3,578	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: 7/1/07

Ending: 6/30/08

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

\*\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12.	_____	\$ _____
13.	_____	\$ _____
14.	_____	\$ _____

\* 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		720		720
4	Clinical Wages (b)		1,440		1,440
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,160	\$	\$ 2,160
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,160		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number STRIVE# 0036921Report Period Beginning: 7/1/07

Ending:

6/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 250	\$ 556,826	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	226,297	1,403,061	3
4	Supply Inventory (priced at )	2,626	39,641	4
5	Short-Term Investments		2,493,854	5
6	Prepaid Insurance	(18,480)	(1,648)	6
7	Other Prepaid Expenses		13,154	7
8	Accounts Receivable (owners or related parties)		1,789,367	8
9	Other(specify):		915,647	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 210,693	\$ 7,209,902	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,366	12
13	Land	68,951	319,861	13
14	Buildings, at Historical Cost	724,445	7,362,592	14
15	Leasehold Improvements, at Historical Cost	43,361	179,437	15
16	Equipment, at Historical Cost	240,710	3,032,532	16
17	Accumulated Depreciation (book methods)	(494,011)	(5,326,417)	17
18	Deferred Charges		(34,290)	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): <b>Construction in progress</b>	20,178	70,561	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 603,634	\$ 5,605,642	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 814,327	\$ 12,815,544	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 135,269	\$ 250,209	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		72,128	29
30	Accrued Salaries Payable	25,155	180,665	30
31	Accrued Taxes Payable (excluding real estate taxes)		7,266	31
32	Accrued Real Estate Taxes(Sch.IX-B)		5,767	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Due to other Funds</b>	(48,717)	1,789,367	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 111,707	\$ 2,305,402	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,599,648	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	<b>ADVANCE</b>		49,028	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,648,676	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 111,707	\$ 3,954,078	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 702,775	\$ 8,861,466	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 814,482	\$ 12,815,544	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>641,979</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>641,979</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>60,796</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>60,796</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>702,775</b>	<b>24</b> *

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

Facility Name &amp; ID Number STRIVE

# 0036921

Report Period Beginning: 7/1/07

Ending: 6/30/08

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,097,361	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,096,161</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		<b>27</b>
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,096,161</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	193,163	31
32	Health Care	449,652	32
33	General Administration	269,561	33
<b>B. Capital Expense</b>			
34	Ownership	59,895	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	63,094	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,035,365</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>60,796</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 60,796</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number **STRIVE**

# **0036921**

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	1,834	2,080	28,716	13.81	9
10	Activity Assistants					10
11	Social Service Workers	1,976	2,080	35,608	17.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,501	4,949	56,503	11.42	14
15	Cook Helpers/Assistants	1,514	1,574	12,308	7.82	15
16	Dishwashers					16
17	Maintenance Workers	1,962	2,172	25,839	11.90	17
18	Housekeepers	835	870	7,386	8.49	18
19	Laundry	320	365	3,083	8.45	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,848	2,080	30,738	14.78	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)	27,237	29,364	320,075	10.90	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,027	45,534	\$ 520,256 *	\$ 11.43	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	26	\$ 1,050	1,3	35
36	Medical Director	24	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	15	580	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)	24	2,340	15,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	89	\$ 6,970		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	586	13,904	10,3	51
52	Certified Nurse Assistants/Aides	791	10,911	10,3	52
53	TOTAL (lines 50 - 52)	1,377	\$ 24,815		53

Facility Name & ID Number **STRIVE**

# **0036921**

Report Period Beginning: **7/1/07**

Ending: **6/30/08**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ANNE DUNBAR			\$	Workers' Compensation Insurance	\$ 10,493	IDPH License Fee	\$	
(SALARY INCLUDED IN MANAGEMENT FEES)				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
LINE 17, COLUMN 3)				FICA Taxes	38,753	Health Care Worker Background Check		
				Employee Health Insurance	16,228	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		C.A.R.F.	1,280	
				LIFE INSURANCE	1,412	IHCA DUES	839	
				PENSION	3,250	DUES & SUBSCRIPTIONS	1,372	
				DISABILITY INSURANCE	4,349			
				TUITION ASSISTANCE	500			
				EMPLOYEE MISC. BENEFITS	5,289	Less: Public Relations Expense	( )	
				CHILD CARE	176	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 80,450	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,491	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
AMERICAN HEALTH ENTERPRISES, INC.			\$ 118,750			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 118,750				In-State Travel	
(Attach a copy of any management service agreement)							EMPLOYEE MILEAGE REIMBURSEMEN	4,505
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount				Seminar Expense	2,595
JOHN PYSE CONSULTING	IT CONSULTANT		\$ 5,656					
LCV CPA'S	YEAR END AUDIT FEES		4,455				Entertainment Expense	( )
CREATIVE SOLUTIONS	MEDICAL RECORDS SOFTW		407				(agree to Sch. V, line 24, col. 8)	
MDI	COMPUTER SOFTWARE		225				TOTAL	\$ 7,100
T6 BROADBAND	EMAIL / INTERNET		238					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 10,980	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number STRIVE

Report Period Beginning: 7/1/07

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	PAINTING	7/01	\$ 1,206	5	\$ 241	\$ 241	\$ 121	\$	\$	\$	\$	\$	\$
2	PAINTING	9/01	3,040	5	608	608	304						
3	PAINTING	6/02	742	5	149	149	72						
4	PAINTING	8/02	1,523	5	304	304	304	155					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 6,511		\$ 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. ILL HEALTHCARE 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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (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. \$ 63,094  
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 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? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- 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 ODSOL, 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 \$5,000, 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.