

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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

<p><b>I. IDPH License ID Number:</b> <u>0036921</u></p> <p><b>Facility Name:</b> <u>STRIVE</u></p> <p><b>Address:</b> <u>415 A Street</u> <u>Prophetstown</u> <u>61277</u>  Number City Zip Code</p> <p><b>County:</b> <u>Whiteside</u></p> <p><b>Telephone Number:</b> <u>815) 537-5358</u> <b>Fax #</b> <u>815-537-2328</u></p> <p><b>HFS ID Number:</b> <u>237136038003</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>4/9/91</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/08</u> to <u>6/30/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MILT RUE</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Margel S. Peddicord, CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Margel S. Peddicord, CPA</u> <u>5300 Jaeger Dr., Springfield, IL 62711</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>217-787-8554</u> Fax # ( ) _____</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>MILT RUE</u>			(Title) <u>CFO</u>		Paid Preparer	(Signed) <u>See Accountant's Compilation Report</u>	(Date) _____	(Print Name and Title) <u>Margel S. Peddicord, CPA</u>		(Firm Name & Address) <u>Margel S. Peddicord, CPA</u> <u>5300 Jaeger Dr., Springfield, IL 62711</u>		(Telephone) <u>217-787-8554</u> Fax # ( ) _____	
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<p>In the event there are further questions about this report, please contact:  Name: <u>Milt Rue</u> Telephone Number: <u>815-778-3683</u>  Email Address: <u>mrue@ahcinc.biz</u></p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE  ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																									

Margel S. Peddicord, CPA  
5300 Jaeger Dr.  
Springfield, IL 62711  
Phone 217-787-8554

#### ACCOUNTANT'S REPORT

The following schedules containing the financial statements and related disclosures of STRIVE, as of and for the year ended June 30, 2009, included in the accompanying prescribed form have been compiled by me:

- XV Balance Sheet
- XVI Changes in Equity
- XVII Income Statement
- X Interest and Real Estate Tax Expenses
- XI Ownership Costs
- XII Rental Costs

My compilation was limited to presenting in the form prescribed by the state of Illinois Department of Healthcare and Family Services, information that is the representation of management. I have not audited or reviewed the financial statements and related disclosures referred to above, and accordingly, do not express an opinion or any other form of assurance on them.

The financial statements and related disclosures referred to above are presented in accordance with the state of Illinois' requirements which differ from generally accepted accounting principles. Accordingly, these financial statements' related disclosures are not designed for those who are not informed about such differences.

I did not compile or prepare Schedule VII Related Parties and Schedule VIII Allocation of Indirect Costs. These schedules were prepared by representatives of STRIVE.

Margel S. Peddicord, CPA  
January 22, 2010

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 7/1/08 Ending: 6/30/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,685			5,685	13
14	TOTALS	5,685			5,685	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.35%

D. How many bed-hold days during this year were paid by the Department? 155 (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 4/9/91 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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

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	70,217	4,355	1,340	75,912		75,912	75,912			1
2	Food Purchase		35,338		35,338		35,338	35,338			2
3	Housekeeping	9,636	2,515		12,151		12,151	12,151			3
4	Laundry	4,451	1,422		5,873		5,873	5,873			4
5	Heat and Other Utilities			18,518	18,518		18,518	(1,546)	16,972		5
6	Maintenance	27,354	7,573	8,470	43,397		43,397	2,807	46,204		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	111,658	51,203	28,328	191,189		191,189	1,261	192,450		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	331,686	26,478	30,410	388,574		388,574	388,574			10
10a	Therapy		500		500		500	500			10a
11	Activities	31,110	3,390		34,500		34,500	34,500			11
12	Social Services	35,976			35,976		35,976	35,976			12
13	CNA Training										13
14	Program Transportation		3,393		3,393		3,393	3,393			14
15	Other (specify):* <b>Dental</b>			2,340	2,340		2,340	2,340			15
16	<b>TOTAL Health Care and Programs</b>	398,772	33,761	35,750	468,283		468,283	468,283			16
	<b>C. General Administration</b>										
17	Administrative			120,000	120,000		120,000	120,000			17
18	Directors Fees										18
19	Professional Services			15,104	15,104		15,104	15,104			19
20	Dues, Fees, Subscriptions & Promotions			2,842	2,842		2,842	2,842			20
21	Clerical & General Office Expenses	31,720	8,354	3,463	43,537		43,537	43,537			21
22	Employee Benefits & Payroll Taxes				86,582		86,582	86,582			22
23	Inservice Training & Education			172	172		172	172			23
24	Travel and Seminar			7,526	7,526		7,526	7,526			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,506	3,506		3,506	3,506			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	31,720	8,354	152,613	279,269		279,269	279,269			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	542,150	93,318	216,691	938,741		938,741	1,261	940,002		29

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

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

Facility Name & ID Number STRIVE

#0036921

Report Period Beginning:

7/1/08

Ending:

6/30/09

## 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			48,559	48,559		48,559	(260)	48,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,966	5,966		5,966		5,966			32
33	Real Estate Taxes			304	304		304		304			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			54,829	54,829		54,829	(260)	54,569			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			60,845	60,845		60,845		60,845			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			60,845	60,845		60,845		60,845			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	542,150	93,318	332,365	1,054,415		1,054,415	1,001	1,055,416			45

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

Facility Name & ID Number **STRIVE**

# **0036921**

Report Period Beginning: **7/1/08**

Ending: **6/30/09**

**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	(1,546)	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	2,547			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 1,001		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			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>	\$ 1,001		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

STRIVE

ID# 0036921

Report Period Beginning: 7/1/08

Ending: 6/30/09

Sch. V Line

**NON-ALLOWABLE EXPENSES**

**Amount**

**Reference**

1	Depreciation on items under \$2,500	\$ (260)	30	1
2	Improvement under \$2,500	2,083	6	2
3	Improvement under \$2,500	724	6	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
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20				20
21				21
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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>		2,547	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,807	0	0	0	0	0	0	0	0	0	0	2,807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>2,807</b>	<b>0</b>	<b>2,807</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>2,807</b>	<b>0</b>	<b>2,807</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

7/1/08

Ending:

6/30/09

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	(260)	0	0	0	0	0	0	0	0	0	0	(260)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,547	0	0	0	0	0	0	0	0	0	0	2,547	45

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
		Winning Wheels	Prophetstown	Lyndon Progress Center	lyndon	Day Treatment Rehabilitation
				Lyndon Play & learn center	Lyndon	child daycare
				Frontier Hollow Apartments	Prophetstown	Independent Living Fac.

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		\$			\$	\$	1
2	V							2
3	V							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		\$			\$	\$ *	14

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

**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								<b>TOTAL</b>	\$	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:

7/1/08

Ending:

6/30/09

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

Facility Name & ID Number

STRIVE

# 0036921

Report Period Beginning:

7/1/08

Ending:

6/30/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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	\$ 24,545	2/1/10	4.5000	\$ 5,966	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	\$ 24,545			\$ 5,966	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	\$ 24,545			\$ 5,966	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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2008 report.		\$	<b>1</b>
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.)		\$	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>304</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>304</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>259</b>	<b>8</b>
	2005	<b>267</b>	<b>9</b>
	2006	<b>274</b>	<b>10</b>
	2007	<b>282</b>	<b>11</b>
	2008		<b>12</b>

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
	<b>TOTALS</b>		\$ <u>304.00</u>	\$ <u>304.00</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 and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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.





1st

WINNING NUMBER	21-04-176-013	PRIZE AMOUNT	\$151.89
DATE OF DRAW	06/05/2009	PRIZE TYPE	Instant
PRIZE VALUE	6303.78		

21-04-176-013  
 WINNING WHEELS & ALS PLACE LTD  
 701 E 3RD ST  
 PROPHETSTOWN IL 61277-0000



2nd

WINNING NUMBER	21-04-176-013	PRIZE AMOUNT	\$151.89
DATE OF DRAW	06/04/2009	PRIZE TYPE	Instant
PRIZE VALUE	6303.78		

21-04-176-013  
 WINNING WHEELS & ALS PLACE LTD  
 701 E 3RD ST  
 PROPHETSTOWN IL 61277-0000

REPORTS BY MAIL - 2008 - CHECKS PAYABLE TO: WHEELSIDE COUNTY COLLECTOR

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning:

7/1/08 Ending:

6/30/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>facility</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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1991	1991	\$ 377,675	\$ 9,442	40	\$ 9,442	\$	\$ 171,900	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Sidewalk & Patio		1992	2,578	64	40	64		1,102	9
10		Carpet		1992	1,690		10			1,690	10
11		Emergency Lighting		1992	723	18	40	18		326	11
12		Mixing valves		1992	1,840	46	40	46		832	12
13		Landscaping		1992	1,075	27	40	27		487	13
14		Storage Shed		1993	2,920	146	20	146		2,348	14
15		Roadway		1995	2,556	183	14	183		1,461	15
16		Sign		1996	179	9	20	9		113	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		1,011	21
22		Garage		1997	36,165	1,447	25	1,447		17,118	22
23		Showers		1998	3,322	166	20	166		1,910	23
24		Carpet		1998	1,753		5			1,753	24
25		Bathroom tile & shower		1999	5,386	539	10	539		5,117	25
26		Sidewalk		2000	1,113	56	20	56		497	26
27		Parking Lot		2000	4,972	497	10	497		4,309	27
28		Front walkway		2001	5,817	291	20	291		2,206	28
29		Steps & sidewalks		2002	4,770	238	20	238		1,748	29
30		Remodel lounge, entry, & nurse station		2002	46,157	2,308	20	2,308		16,155	30
31		Resident rooms carpet		2002	3,982	569	7	569		3,698	31
32		Lift station & Grinder		2005	4,270	285	15	285		1,163	32
33		Hall & Office carpet		2006	4,391	627	7	627		1,568	33
34		Therapy annex		2006	173,000	5,767	30	5,767		14,898	34
35		Sidewalks		2001	13,544	347	39	347		2,696	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	Landscaping	2001	\$ 8,745	\$ 875	10	\$ 875		\$ 6,559	37
38	Steps	2001	1,150	29	39	29		226	38
39	Drainage & grading	2001	4,794	240	20	240		1,818	39
40	Sliding power door	2001	4,274	214	20	214		1,621	40
41	Leasehold improvements	2001	20,083	515	39	515		3,862	41
42	Window treatment	2001	3,629	259	7	259		3,629	42
43	Carpet	2001	14,041	1,003	7	1,003		14,041	43
44	Fencing	2001	1,334	89	15	89		630	44
45	Carpet	2008	928	132	7	132		198	45
46	Main entry tile	2009	3,930	393	5	393		393	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)		\$ 771,735	\$ 26,901		\$ 26,901	\$	\$ 296,424	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 116,545	\$ 10,625	\$ 10,625	\$		\$ 89,400	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	70,298					70,298	73
74								74
75	TOTALS	\$ 186,843	\$ 10,625	\$ 10,625	\$		\$ 159,698	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	\$		\$ 48,480	76
77										77
78										78
79										79
80	TOTALS			\$ 53,867	\$ 10,773	\$ 10,773	\$		\$ 48,480	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)	\$ 1,081,426	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,299	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,299	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 504,602	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		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning: 7/1/08

Ending: 6/30/09

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: NA

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

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

**XIII. EXPENSES RELATING TO 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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	Other (specify):									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**# **0036921**Report Period Beginning: **7/1/08**

Ending:

**6/30/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/09**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 250	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	261,854		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 262,104	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951		13
14	Buildings, at Historical Cost	774,544		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	240,710		16
17	Accumulated Depreciation (book methods)	(504,863)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See attached</u>	23,919		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 603,261	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 865,365	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	24,545		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 24,545	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 24,545	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 840,820	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 865,365	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 702,775	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 702,775	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	61,235	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	76,810	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)	\$ 138,045	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 840,820	24 *

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

**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	\$ 1,110,467	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,109,267</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	2,841	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>\$ 2,841</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	2,577	28
28a	Transportation	965	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,542</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,115,650</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	191,189	31
32	Health Care	468,283	32
33	General Administration	279,269	33
<b>B. Capital Expense</b>			
34	Ownership	54,829	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	60,845	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>\$ 1,054,415</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>61,235</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>\$ 61,235</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? \_\_\_\_\_ 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:

**7/1/08**

Ending:

**6/30/09**

**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				9
10	Activity Assistants	1,900	31,003	14.96	10
11	Social Service Workers	1,912	35,849	17.24	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,077	27,445	11.51	14
15	Cook Helpers/Assistants	4,073	43,075	9.52	15
16	Dishwashers				16
17	Maintenance Workers	2,117	27,062	11.88	17
18	Housekeepers	803	9,636	10.97	18
19	Laundry	371	4,452	10.97	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative	1,883	31,597	15.26	22
23	Office Manager				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)	27,576	332,031	10.98	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	42,712	542,150 *	11.55	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	294	\$ 1,340	1.3	35
36	Medical Director	30	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	540	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)				46
47	Dental consultant	29	2,340	15.3	47
48					48
49	TOTAL (lines 35 - 48)	364	\$ 7,220		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$		50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	2,660	29,245	10.3	52
53	TOTAL (lines 50 - 52)	2,660	\$ 29,245		53

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	\$ 11,917	IDPH License Fee	\$	
(SALARY INCLUDED IN MANAGEMENT FEES, LINE 17, COLUMN 3)				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	40,067	Health Care Worker Background Check		
				Employee Health Insurance	17,437	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		CARF	1,280	
				Disability & Life Insurance	6,855	IHCA	839	
				Pension	3,250	DUES AND SUBSCRIPTIONS	565	
				Child Care	1,470	Other	158	
				Other benefits	4,066			
				Dental insurance	1,520	Less: Public Relations Expense	( )	
						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)	\$ 86,582	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,842	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
American Health Enterprises			\$ 120,000			\$	Out-of-State Travel	\$
							In-State Travel	6,483
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,000				Seminar Expense	1,043
C. Professional Services							Entertainment Expense	( )
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
LVC, CPA	YEAR END AUDIT FEES		\$ 9,565	TOTAL		\$	TOTAL	\$ 7,526
JOHN PYSE CONSULTING	COMPUTER CONSULTING		4,314					
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE		600					
JCM CONSULTING	EMPLOYEE REVIEW SOFTW		625					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,104					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number STRIVE

# 0036921

Report Period Beginning: 7/1/08

Ending: 6/30/09

## 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. II. Healthcare Association \$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? 5
- (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. \$ 60,845  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ none Has any meal income been offset against related costs? no Indicate the amount. \$ \_\_\_\_\_
- (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. \$ na
- c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_
- 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Lindgren, Callihan, Van Odsol, CPAs
- (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? NA  
Attach invoices and a summary of services for all architect and appraisal fees.

**S.T.R.I.V.E.**  
2009 Cost Report  
Travel and Seminars

Title of Seminar DD Seminar  
Location Springfield  
Dates 5/14/2009  
Attendees Anne Dunbar  
Cost \$ 293

Title of Seminar IHCA Convention  
Location Peoria, IL  
Dates 9/8/09 - 9/11/09  
Attendees Anne Dunbar  
Cost \$ 395

Title of Seminar IL Dietary Management Assoc  
Location Galena, IL  
Dates 4/2/09 - 4/3/09  
Attendees Patricia Page  
Cost \$ 152

Title of Seminar The ARC of Illinois  
Location Frankfort, IL  
Dates 9/27/2009  
Attendees Anne Dunbar  
Cost \$ 140

Title of Seminar VNS Seminar  
Location Freeport, IL  
Dates 1/20/2009  
Attendees Anne Dunbar  
Cost \$ 63

Reimbursed Employee Travel & Mileage \$ 6,483

**Total** **\$ 7,526**

STRIVE  
YEAR ENDED 06/30/09

**BALANCE SHEET**

Page 17, line 23

Construction in Progress	\$ 21,591
Loan Amortization Fee	<u>2,328</u>
Total	<u><u>\$ 23,919</u></u>