



Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	16	Intermediate/DD	16	5,840	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			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	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,559			5,559	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,559			5,559	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.19%

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

104 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 04/09/1991

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2015 Fiscal Year: 06/30/2015

\* 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	75,441	5,094	863	81,398		81,398		81,398		1
2	Food Purchase		51,713		51,713		51,713		51,713		2
3	Housekeeping	30,497	5,673		36,170		36,170		36,170		3
4	Laundry	5,394	3,785		9,179		9,179		9,179		4
5	Heat and Other Utilities			21,999	21,999		21,999	(2,627)	19,372		5
6	Maintenance	40,129	15,304	4,375	59,808		59,808		59,808		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	151,461	81,569	27,237	260,267		260,267	(2,627)	257,640		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,750	2,750		2,750		2,750		9
10	Nursing and Medical Records	367,079	23,034	17,758	407,871		407,871		407,871		10
10a	Therapy			432	432		432		432		10a
11	Activities	56,991	3,671	300	60,962		60,962		60,962		11
12	Social Services	44,972			44,972		44,972		44,972		12
13	CNA Training		509		509		509		509		13
14	Program Transportation		11,255		11,255	(9,447)	1,808		1,808		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>	469,042	38,469	23,580	531,091	(9,447)	521,644		521,644		16
	<b>C. General Administration</b>										
17	Administrative			133,131	133,131		133,131		133,131		17
18	Directors Fees										18
19	Professional Services			19,141	19,141		19,141		19,141		19
20	Dues, Fees, Subscriptions & Promotions			2,453	2,453		2,453	(120)	2,333		20
21	Clerical & General Office Expenses	39,894		6,481	46,375		46,375	21,624	67,999		21
22	Employee Benefits & Payroll Taxes			97,859	97,859		97,859	2,466	100,325		22
23	Inservice Training & Education			209	209		209		209		23
24	Travel and Seminar			794	794		794		794		24
25	Other Admin. Staff Transportation			7,251	7,251		7,251		7,251		25
26	Insurance-Prop.Liab.Malpractice			3,762	3,762		3,762		3,762		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	39,894		271,081	310,975		310,975	23,970	334,945		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	660,397	120,038	321,898	1,102,333	(9,447)	1,092,886	21,343	1,114,229		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: 07/01/2014 Ending: 06/30/2015

## 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			45,592	45,592		45,592	(177)	45,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,875	9,875		9,875		9,875			32
33	Real Estate Taxes			291	291		291		291			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			55,758	55,758		55,758	(177)	55,581			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					9,447	9,447		9,447			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,106	65,106		65,106		65,106			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			65,106	65,106	9,447	74,553		74,553			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	660,397	120,038	442,762	1,223,197		1,223,197	21,166	1,244,363			45

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

Facility Name & ID Number **STRIVE**

# **0036921**

Report Period Beginning: **07/01/2014**

Ending: **06/30/2015**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(2,627)	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	(120)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,747)		\$	30

<b>BHF USE ONLY</b>						
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	
		<b>Amount</b>	<b>Reference</b>	
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)	24,090	21,22	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 24,090		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 21,343		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		xx	\$ 9,447	14.2	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>			\$ 9,447		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,627)	0	0	0	0	0	0	0	0	0	0	(2,627)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,627)</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>(2,627)</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	(120)	0	0	0	0	0	0	0	0	0	0	(120)	20
21	Clerical & General Office Expenses	0	21,624	0	0	0	0	0	0	0	0	0	21,624	21
22	Employee Benefits & Payroll Taxes	0	2,466	0	0	0	0	0	0	0	0	0	2,466	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>(120)</b>	<b>24,090</b>	<b>0</b>	<b>23,970</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,747)</b>	<b>24,090</b>	<b>0</b>	<b>21,343</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

07/01/2014 Ending:

Summary B

06/30/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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>	<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>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(2,747)</b>	<b>24,090</b>	<b>0</b>	<b>21,343</b>	<b>45</b>								

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS	100	WINNING WHEELS	PROPHETSTOWN	LYNDON PROGRESS CENTER	LYNDON	DAY TREATMENT
				LYNDON PLAY & LEARN CENTER	LYNDON	CHILD CARE
				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		\$			\$	\$	1
2	V							2
3	V							3
4	V	ADMINISTRATIVE OVERHEAD						4
5	V	21 CLERICAL SALARIES		WINNING WHEELS INC (ADMINISTRATIVE FUND)		21,624	21,624	5
6	V	22 BENEFITS		(SEE DETAILS, SCHEDULE VIII, PAGE 8)		2,466	2,466	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 24,090	\$ * 24,090	14

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

Facility Name & ID Number

STRIVE

# 0036921

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

**VII. RELATED PARTIES**

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	0						2
3	DAVID MICKLEY	0						3
4	CONNIE DEMARANVILLE	0						4
5	BILL SULLIVAN	0						5
6	KYLE GIBSON	0						6
7	MEREDITH HAMMER	0						7
8	MARY ANN HILL	0						8
9	RICK TURNROTH	0						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

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

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning: 07/01/2014

Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization WINNING WHEELDS ADMINISTRATIVE FU  
 Street Address 501 6TH AVENUE WEST  
 City / State / Zip Code LYNDON IL 61261  
 Phone Number ( 8157783610  
 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	21	CLERICAL SALARIES	7,320,171	7	\$ 208,797	\$ 208,797	758,118	\$ 21,624	1
2	22	FICA	7,320,171	7	12,957		758,118	1,342	2
3	22	WORKERS COMP	7,320,171	7	4,048		758,118	419	3
4	22	LIFE INSURANCE	7,320,171	7	670		758,118	69	4
5	22	HEALTH INSURANCE	7,320,171	7	1,327		758,118	137	5
6	22	VISION INSURANCE	7,320,171	7	161		758,118	17	6
7	22	DENTAL INSURANCE	7,320,171	7	759		758,118	79	7
8	22	ST & LT DISABILITY INS	7,320,171	7	435		758,118	45	8
9	22	CHILD CARE	7,320,171	7	3,350		758,118	347	9
10	22	OTHER	7,320,171	7	102		758,118	11	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 232,606	\$ 208,797		\$ 24,090	25

Facility Name & ID Number

STRIVE

# 0036921

Report Period Beginning:

07/01/2014

Ending:

06/30/2015

**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**					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							\$	\$			\$					
2																
3																
4																
5																
<b>Working Capital</b>																
6	FARMERS NATIONAL BANK	X		LINE OF CREDIT		10/24/12	250,000	250,000	10/15/15	3.9500	9,875					
7																
8																
9	<b>TOTAL Facility Related</b>						\$ 250,000	\$ 250,000			\$ 9,875					
<b>B. Non-Facility Related*</b>																
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$ 250,000	\$ 250,000			\$ 9,875					

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.		\$	<b>311</b>	1											
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>291</b>	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(20)</b>	3											
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>311</b>	4											
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5											
6. Subtract a refund of real estate taxes. 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>		\$		6											
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>291</b>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<b>311</b>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	<b>316</b>	9												
	2012	<b>320</b>	10												
	2013	<b>321</b>	11												
	2014	<b>291</b>	12												

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT Robin Jackson

TELEPHONE 815-778-3683 FAX #: 815-778-4503

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>PRT SE NW SEC 4 TWP 19 RNG</u>	\$ <u>290.98</u>	\$ <u>290.98</u>
2. _____	<u>5MR 10236-94 26402X</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>290.98</u></u>	\$ <u><u>290.98</u></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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number STRIVE

# 0036921 Report Period Beginning:

07/01/2014 Ending:

06/30/2015

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLER Number of Stories 1

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).

FRONTIER HOLLOW APARTMENTS, INDEPENDENT LIVING APTS 16 ONE BEDROOM UNITS

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>		<u>1991</u>	\$ <u>10,207</u>	1
2			<u>1995-2007</u>	<u>58,744</u>	2
3	<b>TOTALS</b>			\$ <b>68,951</b>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	\$ 228,551	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	REMODELING	1992		7,906	155	34	155		5,370	9
10	REMODELING	1993		2,920		20			2,920	10
11	REMODELING	1995		2,556	183	14	183		4,838	11
12	REMODELING	1997		43,489	1,527	15	1,527		33,008	12
13	REMODELING	1998		5,075	166	12.5	166		4,659	13
14	REMODELING	1999		5,386		10			5,386	14
15	REMODELING	2000		6,085	56	15	56		5,803	15
16	REMODELING	2001		42,569	1,121	21.89	1,121		28,282	16
17	REMODELING	2002		96,262	3,150	13	3,150		65,214	17
18	REMODELING	2005		4,270	285	15	285		2,871	18
19	REMODELING	2006		177,391	6,080	18.5	6,080		54,202	19
20	REMODELING	2008		928	133	7	133		994	20
21	REMODELING	2009		16,840	1,810	7.33	1,810		12,117	21
22	REPLACE WALL CARPET THROUGHOUT BUILDING	2010		5,208	744	7	744		4,092	22
23	ROOF ON MAIN BUILDING	2010		16,654	1,110	15	1,110		5,551	23
24	PAINTING MAIN HALLWAY AND DINING ROOM	2011		3,196	457	7	457		2,055	24
25	FLOORING AND WALL CARPET IN MAIN HALLWAYS	2012		5,212	1,042	5	1,042		3,648	25
26	CARPER IN FOUR RESIDENT ROOMS	2012		4,101	586	7	586		2,051	26
27	WIRING FOR GENERATOR PREPARATION	2014		10,750	1,536	7	1,536		1,792	27
28										28
29	REMODELING	1996		1,805	9	15	9		1,793	29
30										30
31										31
32										32
33										33
34										34
35										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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 836,278	\$ 29,592		\$ 29,592	\$	\$ 475,197	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 58,349	\$ 7,398	\$ 7,398	\$	7.12	\$ 35,509	71
72	Current Year Purchases	5,400	286	286		7	286	72
73	Fully Depreciated Assets	181,837				8.75	181,837	73
74								74
75	TOTALS	\$ 245,586	\$ 7,684	\$ 7,684	\$		\$ 217,632	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	\$ 53,867	\$	\$	\$	5	\$ 53,867	76
77	RESIDENT OUTINGS	2009 FORD SHUTTLE BUS	2009	56,975	8,139	8,139		7	44,766	77
78										78
79										79
80	TOTALS			\$ 110,842	\$ 8,139	\$ 8,139	\$		\$ 98,633	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)	\$ 1,261,657	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,415	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,415	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)	\$ 791,462	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.

**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

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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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.

**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 checked="" 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	SUM OF line 9, col. 1 and 2 (e)	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	5 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	10a.3	hrs		6	432		6	432	4
5	Physician Care		visits							5
6	Dental Care	15.3	visits		29	2,340		29	2,340	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10.3	# of prescrpts		9	599		9	599	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Medicare Therapy</u>	10A.3			316	432		316	432	12
13	Other (specify): <u>Pysiatrian</u>	9.3			22	2,750		22	2,750	13
14	<b>TOTAL</b>			\$	382	\$ 6,553	\$	382	\$ 6,553	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 &amp; ID Number STRIVE

# 0036921

Report Period Beginning: 07/01/2014

Ending:

06/30/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015

(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	\$ 54,625	\$ 546,253	1
2	Cash-Patient Deposits	1,804	38,501	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	128,722	975,472	3
4	Supply Inventory (priced at <u>COST</u> )	5,986	49,297	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,150	17,333	6
7	Other Prepaid Expenses	8,720	96,257	7
8	Accounts Receivable (owners or related parties)		1,226,694	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 201,007	\$ 2,949,807	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	369,861	13
14	Buildings, at Historical Cost	836,278	16,182,193	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	356,428	3,842,949	16
17	Accumulated Depreciation (book methods)	(791,462)	(10,447,056)	17
18	Deferred Charges	1,242	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,446,362	21
22	Other Long-Term Assets (spec <u>NON DEPR ASSET</u> )		9,061	22
23	Other(specify):		266	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 471,437	\$ 11,436,751	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 672,444	\$ 14,386,558	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 104,666	\$ 1,046,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,804	43,034	28
29	Short-Term Notes Payable	250,000	2,802,511	29
30	Accrued Salaries Payable	33,327	333,327	30
31	Accrued Taxes Payable (excluding real estate taxes)		99,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)	291	17,450	32
33	Accrued Interest Payable	3,417	68,330	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>WORKERS COMP INS</u>	2,056	41,128	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 395,561	\$ 4,451,652	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,251,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>PUBLIC AID ADVANCE</u>		102,126	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,353,332	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 395,561	\$ 9,804,984	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 276,883	\$ 4,581,574	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 672,444	\$ 14,386,558	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,026,237	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,026,237	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(59,502)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) <b>NET INCOME (LOSS)</b>	(385,161)	16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (444,663)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 4,581,574	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,158,037	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,156,837</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,078	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,078</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,780	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>\$ 3,780</b>	23
<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>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION</b>	9,447	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 9,447</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,173,142</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	260,267	31
32	Health Care	531,091	32
33	General Administration	310,975	33
<b>B. Capital Expense</b>			
34	Ownership	55,758	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	74,553	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>\$ 1,232,644</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(59,502)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (59,502)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,156,837	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,156,837</b>	49

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

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

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

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

Facility Name & ID Number **STRIVE**

# 0036921

Report Period Beginning: 07/01/2014

Ending:

06/30/2015

**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	1,868	2,133	37,044	17.37	9
10	Activity Assistants	1,431	1,559	19,947	12.79	10
11	Social Service Workers	1,849	2,105	44,972	21.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,772	1,884	26,840	14.25	14
15	Cook Helpers/Assistants	4,537	4,989	48,601	9.74	15
16	Dishwashers					16
17	Maintenance Workers	2,040	2,244	40,129	17.88	17
18	Housekeepers	2,354	2,649	30,497	11.51	18
19	Laundry	553	553	5,394	9.75	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,839	2,087	39,894	19.12	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	25,694	28,469	367,079	12.89	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	43,937	48,672	\$ 660,397 *	\$ 13.57	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	23	\$ 863	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	599	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	6	300	11.3	44
45	Social Service Consultant				45
46	Other(specify) <u>DENTAL</u>	29	2,340	15.3	46
47	<u>Pysiatrain</u>	22	2,750	9.3	47
48					48
49	TOTAL (lines 35 - 48)	89	\$ 6,852		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	509	15,200	10.3	51
52	Certified Nurse Assistants/Aides	141	1,959	10.3	52
53	TOTAL (lines 50 - 52)	650	\$ 17,159		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	ADMINISTRATOR	0	\$ 79,444	Workers' Compensation Insurance	\$ 21,547	IDPH License Fee	\$ EXEMPT		
(INCLUDED IN AMERICAN HEALTH ENTERPRISES IN B BELOW)			(79,444)	Unemployment Compensation Insurance		Advertising: Employee Recruitment	637		
				FICA Taxes	52,222	Health Care Worker Background Check (Indicate # of checks performed 2)	100		
				Employee Health Insurance	7,818	Patient Background Checks 2	20		
				Employee Meals		CARF	737		
				Illinois Municipal Retirement Fund (IMRF)*		COMMUNITY RELATIONS	120		
				LIFE INSURANCE	3,510	IHCA DUES	839		
				DISABILITY INS	3,273				
				CHILD CARE	698	Less: Public Relations Expense	(120)		
				PROF LICENSE AND TRAINING	455	Non-allowable advertising	( )		
				DENTAL/VISION INSURANCE	2,920	Yellow page advertising	( )		
				OTHER XMAS PARTY/GIFTS/ ANNUAL 5YR BANQUET	7,882				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 100,325	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,333		
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			\$ 133,131				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	794	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 133,131	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	( )	
C. Professional Services							TOTAL		\$ 794
Vendor/Payee	Type		Amount						
SILVERCHAIR	SOFTWARE FEES		889						
JOHN PYSE CONSULTING	IT CONSULTANT		5,431						
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE		600						
FROST, RUTTENBERG, ROTHBA	AUDIT / 990 RETURN		10,568						
CAREVOYANT	MDS SOFTWARE		1,195						
OTHER	OTHER CONSULT		458						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 19,141						

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Amount of Expense Amortized Per Year
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1	FLOORING IN RESIDEN	2011	\$ 1,242	7	\$	\$	\$	\$	\$ 90	\$ 177	\$ 177	\$ 177	\$ 177
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,242		\$	\$	\$	\$	\$ 90	\$ 177	\$ 177	\$ 177	\$ 177

Facility Name &amp; ID Number STRIVE

# 0036921

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

## 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. IL HEALTH CARE ASSOC \$839
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,351 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO XX 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. \$ 65,106  
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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 9,447  
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. \$ NONE**
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: FROST, RUTTENBERG, & ROTHBLATT
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.