

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning:

07/01/2017

Ending: 6/30/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Winning Wheels Administrative Fund  
 Street Address 501 6th Ave West  
 City / State / Zip Code Lyndon IL 61261  
 Phone Number ( 815-778-3683  
 Fax Number ( 815-778-4503

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES / BENEFITS 6,710,915	7	\$ 193,747	\$ 193,747	759,881	\$ 21,938	1
2	22	FICA	SALARIES / BENEFITS 6,710,915	7	11,507		759,881	1,303	2
3	22	WORKERS COMP	SALARIES / BENEFITS 6,710,915	7	5,058		759,881	573	3
4	22	LIFE INSURANCE	SALARIES / BENEFITS 6,710,915	7	378		759,881	43	4
5	22	HEALTH INSURANCE	SALARIES / BENEFITS 6,710,915	7	1,077		759,881	122	5
6	22	VISION INSURANCE	SALARIES / BENEFITS 6,710,915	7	146		759,881	17	6
7	22	DENTAL INSURANCE	SALARIES / BENEFITS 6,710,915	7	435		759,881	49	7
8	22	ST & LT DISABILITY INS	SALARIES / BENEFITS 6,710,915	7	1,423		759,881	161	8
9	22	CHILD CARE	SALARIES / BENEFITS 6,710,915	7	6,150		759,881	696	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 219,921	\$ 193,747		\$ 24,902	25

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# 0036921

Report Period Beginning:

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06/30/2018

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

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$								
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>					\$	\$			\$								
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$								
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$								

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 2017 report.	\$	<b>296</b>	<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>296</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$		<b>3</b>
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		<b>4</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>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<b>321</b>	<b>8</b>
	2014	<b>291</b>	<b>9</b>
	2015	<b>301</b>	<b>10</b>
	2016	<b>301</b>	<b>11</b>
	2017	<b>296</b>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$	<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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT Robin Landis

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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-04-176-013</u>	<u>PRT SE NW SEC 4 TWP 19 RNG</u>	\$ <u>296.00</u>	\$ <u>296.00</u>
2. _____	<u>5MR 10236-94-26402X</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>296.00</u>	\$ <u>296.00</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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:

07/01/2017 Ending:

06/30/2018

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? [X] (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? [X] (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 APARTMENTS 16 ONE BEDROOM UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column. Rows include FACILITY (1991, \$10,207), 1995-2007 (\$58,744), and TOTALS (\$68,951).

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	\$ 9,441	40	\$ 9,441	\$	\$ 256,876	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	REMODELING	1992		7,906	155	34	155		5,526	9
10	REMODELING	1993		2,920		20			2,920	10
11	REMODELING	1995		2,556		14			2,556	11
12	REMODELING	1996		1,805		15			1,805	12
13	REMODELING	1997		38,293	1,447	15	1,447		32,265	13
14	REMODELING	1998		5,075	83	12.5	83		5,075	14
15	REMODELING	1999		5,386		15			5,386	15
16	REMODELING	2000		6,085	291	15	291		9,795	16
17	REMODELING	2001		42,570	1,636	21.89	1,636		31,646	17
18	REMODELING	2002		96,262	3,061	13	3,061		74,568	18
19	REMODELING	2005		4,270	285	15	285		3,724	19
20	REMODELING	2006		177,391	5,767	18.5	5,767		71,188	20
21	REMODELING	2008		928		7			928	21
22	REMODELING	2009		16,840	997	7.33	997		15,345	22
23	REPLACE WALL CARPET THROUGHOUT BUILDING	2010		5,208		7			5,208	23
24	ROOF ON MAIN BUILDING	2010		16,654	1,110	15	1,110		8,882	24
25	PAINTING MAIN HALLWAY AND DINING ROOM	2011		3,196	228	7	228		3,196	25
26	FLOORING AND WALL CARPET IN MAIN HALLWAYS	2012		5,212		5			5,212	26
27	CARPET IN FOUR RESIDENT ROOMS	2012		4,101	586	7	586		3,808	27
28	WIRING FOR GENERATOR PREPARATION	2014		10,750	538	7	538		2,240	28
29										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

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)	\$	\$ 831,083		\$ 25,625	\$	\$ 25,625	\$	\$ 548,149	70

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

Facility Name & ID Number STRIVE

# 0036921

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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	\$ 22,792	\$ 2,614	\$ 2,614	\$	7.65	\$ 11,555	71
72	Current Year Purchases	2,968	398	398		3	398	72
73	Fully Depreciated Assets	232,201				8.75	232,201	73
74								74
75	TOTALS	\$ 257,961	\$ 3,012	\$ 3,012	\$		\$ 244,154	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	2009 FORD SHUTTLE BUS	2009	\$ 56,975	\$	\$	\$	7	\$ 56,975	76
77	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	53,867				5	53,867	77
78										78
79										79
80	TOTALS			\$ 110,842	\$	\$	\$		\$ 110,842	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)	\$ 1,268,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,637	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,637	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)	\$ 903,145	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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9.3	visits		12	3,000		12	3,000	5
6	Dental Care	15.3	visits		31	2,340		31	2,340	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10.3	# of prescripts		14	675		14	675	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>MEDICARE THERAP</u>	10A.3			1	165		1	165	12
13	Other (specify): <u>PSYCH CONSULT</u>	10.3			15	2,250		15	2,250	13
14	TOTAL			\$	73	\$ 8,430	\$	73	\$ 8,430	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2018

(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	\$ 7,805	\$ 32,964	1
2	Cash-Patient Deposits	4,443	41,507	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,200 )	98,831	681,130	3
4	Supply Inventory (priced at COST )	9,578	35,264	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,150	30,614	6
7	Other Prepaid Expenses	10,816	99,334	7
8	Accounts Receivable (owners or related parties)		710,015	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 132,623	\$ 1,630,828	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	146,351	13
14	Buildings, at Historical Cost	831,083	14,352,980	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	368,803	3,129,647	16
17	Accumulated Depreciation (book methods)	(903,145)	(8,089,908)	17
18	Deferred Charges		31,227	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		566,470	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 365,692	\$ 10,136,767	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 498,315	\$ 11,767,595	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 161,926	\$ 1,019,632	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,443	41,507	28
29	Short-Term Notes Payable	257,834	1,955,781	29
30	Accrued Salaries Payable	15,854	233,657	30
31	Accrued Taxes Payable (excluding real estate taxes)		77,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,852	32
33	Accrued Interest Payable		37,907	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>	\$ 440,057	\$ 3,389,340	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,050,982	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>	\$	\$ 5,050,982	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 440,057	\$ 8,440,322	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 58,258	\$ 3,327,273	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 498,315	\$ 11,767,595	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,690,839</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,690,839</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(38,315)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)	(338,307)	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (376,622)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,314,217</b>	<b>24</b> *

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

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**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	\$ 1,170,959	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,169,759	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,786	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,786	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	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>	(10,451)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (10,451)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,161,094	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	227,118	31
32	Health Care	539,693	32
33	General Administration	334,669	33
<b>B. Capital Expense</b>			
34	Ownership	28,896	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,605	35
36	Provider Participation Fee	66,428	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,199,409	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(38,315)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (38,315)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,170,959	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>	\$ 1,170,959	49

\* 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.

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**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	1,749	2,073	38,096	18.38	9
10	Activity Assistants	1,546	1,798	22,293	12.40	10
11	Social Service Workers	1,696	1,859	40,995	22.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,083	2,281	33,606	14.73	14
15	Cook Helpers/Assistants	3,514	4,015	35,829	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,535	2,031	34,140	16.81	17
18	Housekeepers	3,007	3,224	33,845	10.50	18
19	Laundry	400	400	3,344	8.36	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,755	1,995	40,082	20.09	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)	24,677	27,203	373,398	13.73	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	41,962	46,879	\$ 655,628 *	\$ 13.99	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	30	\$ 1,212	1.3	35
36	Medical Director	12	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	14	675	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>DENTAL</u>	31	2,340	15.3	46
47					47
48	<u>PSYCHOLOGICAL</u>	15	2,250	10.3	48
49	TOTAL (lines 35 - 48)	102	\$ 9,477		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	12	\$ 1,200	10.3	50
51	Licensed Practical Nurses	520	14,500	10.3	51
52	Certified Nurse Assistants/Aides	200	7,744	10.3	52
53	TOTAL (lines 50 - 52)	732	\$ 23,444		53



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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IHCA \$960
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,980 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. \$ 66,428  
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? none 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. \$ 10,451  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
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? yes  
Firm Name: Marcum LLP
- (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