		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

I. IDPH License ID Number: 0036921

Facility Name: STRIVE

Address: 415 A STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5358 **Fax #** 815-537-2328

HFS ID Number:

Date of Initial License for Current Owners: 04/09/1991

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501(c)(3)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2009 to 06/30/2010 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 02/04/2011 (Date)

(Type or Print Name) MILT RUE

(Title) CFO

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: MILT RUE Telephone Number: 815-778-3683
Email Address:

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**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	5,727			5,727	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,727			5,727	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.07%

D. How many bed-hold days during this year were paid by the Department?
113 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	68,458	6,218	1,190	75,866		75,866		75,866			1
2	Food Purchase		48,949		48,949		48,949		48,949			2
3	Housekeeping	10,291	5,904		16,195		16,195		16,195			3
4	Laundry	5,563	1,723		7,286		7,286		7,286			4
5	Heat and Other Utilities			15,392	15,392		15,392	(1,455)	13,937			5
6	Maintenance	33,543	21,570	7,566	62,679		62,679	2,943	65,622			6
7	Other (specify):*											7
8	**TOTAL General Services**	117,855	84,364	24,148	226,367		226,367	1,488	227,855			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	327,612	23,799	30,257	381,668		381,668		381,668			10
10a	Therapy			580	580		580		580			10a
11	Activities	32,886	3,175		36,061		36,061		36,061			11
12	Social Services	37,416			37,416		37,416		37,416			12
13	CNA Training											13
14	Program Transportation		4,853		4,853		4,853		4,853			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	397,914	31,827	33,837	463,578		463,578		463,578			16
	C. General Administration											
17	Administrative			120,000	120,000		120,000		120,000			17
18	Directors Fees											18
19	Professional Services			18,163	18,163		18,163		18,163			19
20	Dues, Fees, Subscriptions & Promotions			2,951	2,951		2,951	(78)	2,873			20
21	Clerical & General Office Expenses	32,600	5,658	3,975	42,233		42,233		42,233			21
22	Employee Benefits & Payroll Taxes			91,630	91,630		91,630	489	92,119			22
23	Inservice Training & Education			191	191		191		191			23
24	Travel and Seminar			8,853	8,853		8,853		8,853			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,669	3,669		3,669		3,669			26
27	Other (specify):*											27
28	**TOTAL General Administration**	32,600	5,658	249,432	287,690		287,690	411	288,101			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	548,369	121,849	307,417	977,635		977,635	1,899	979,534			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: 07/01/2009 Ending: 06/30/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,962	45,962		45,962	(809)	45,153			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			816	816		816		816			32
33	Real Estate Taxes			308	308		308		308			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,086	47,086		47,086	(809)	46,277			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,587	60,587		60,587		60,587			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,587	60,587		60,587		60,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	548,369	121,849	415,090	1,085,308		1,085,308	1,090	1,086,398			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: 07/01/2009 Ending: 06/30/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(1,455)	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	(78)	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 SEE PAGE 5A	2,134			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 601		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 601		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation on items under $2,500	$ (809)	30	1
2	Improvement under $2,500	817	6	2
3	Improvement under $2,500	583	6	3
4	Improvement under $2,500	1,543	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	2,134		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number STRIVE **#** 0036921 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,455)	0	0	0	0	0	0	0	0	0	0	(1,455)	5
6	Maintenance	2,943	0	0	0	0	0	0	0	0	0	0	2,943	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,488	0	0	0	0	0	0	0	0	0	0	1,488	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	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	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(78)	0	0	0	0	0	0	0	0	0	0	(78)	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	489	0	0	0	0	0	0	0	0	0	489	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	**TOTAL General Administration**	(78)	489	0	0	0	0	0	0	0	0	0	411	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,410	489	0	0	0	0	0	0	0	0	0	1,899	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(809)	0	0	0	0	0	0	0	0	0	0	(809)	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	**TOTAL Ownership**	(809)	0	0	0	0	0	0	0	0	0	0	(809)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	601	489	0	0	0	0	0	0	0	0	0	1,090	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 PROGRES	LYNDON	DAYTREATMENT
				CENTER		REHABILITATION
				LYNDON PLAY &	LYNDON	CHILD DAYCARE
				LEARN CENTER		
				FRONTIER HOLLOV	PROPHETSTOWN	INDEPENDENT
				APARTMENTS		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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	CHILDCARE BENEFITS	$ 2,260	LYNDON PLAY & LEARN CENTER	0.00%	$ 2,749	$ 489	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			$ 2,260			$ 2,749	$ * 489	14

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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: 07/01/2009 Ending: 6/30/2010

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	TOTALS					$	$		$	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IFF		X	MORTGAGE	$3,120.15	03/2005	$ 167,363	$	02/1/10	4.5000	$ 816	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,120.15		$ 167,363	$			$ 816	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 167,363	$			$ 816	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 308	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 308	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	269	8
	2006	274	9
	2007	282	10
	2008	304	11
	2009	308	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT MILTON RUE

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-04-176-013	PT SE NW SEC 4 TWP 19 RNG	$ 307.52	$ 307.52
2.		5 MF 10236-94 26402x	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 307.52	$ 307.52

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

WHITESIDE COUNTY
REAL ESTATE TAX BILL

DARLENE HOOK, WHITESIDE COUNTY TREASURER

OFFICE HOURS 8:30AM - 4:30PM
MONDAY - FRIDAY PHONE: 815-772-5196

PIN NUMBER	TOWNSHIP	TAX CODE	CLASS CODE		MARKET VALUE
21-04-176-013	Prophetstown	02005	1023	2009 PAYABLE 2010	10,215

Taxing Body	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Difference Amount	Pension Amount	Library Amount
WHITESIDE COUNTY	1.0832	$35.79	1.0867	$37.02	$1.23	$11.65	$0.00
PROPHETSTOWN FIRE	0.4096	$13.53	0.4117	$14.02	$0.49	$0.00	$0.00
SAUK VALLEY NO 506	0.4447	$14.69	0.4421	$15.05	$0.36	$0.31	$0.00
PROPHETSTOWN PARK	0.3735	$12.34	0.4251	$14.47	$2.13	$0.81	$0.00
PROPHETSTOWN TOWNSHIP	0.3842	$12.69	0.3760	$12.80	$0.11	$0.00	$0.00
PROPHETSTOWN TOWNSHIP ROAD	0.5359	$17.71	0.5360	$18.25	$0.54	$0.00	$0.00
PTOWN-LYN-TAMP UNIT #3	4.8940	$161.70	4.7914	$163.15	$1.45	$12.87	$0.00
PROPHETSTOWN CITY	1.0692	$35.33	0.9621	$32.76	($2.57)	$8.05	$4.10
Totals	**9.1943**	**$303.78**	**9.0311**	**$307.52**	**$3.74**	**$33.69**	**$4.10**

RECEIVED NOV 1 2

PENALTY INTEREST OF 1 1/2% PER MONTH
ADDED AFTER EACH INSTALLMENT DUE DATE
FOR EACH MONTH OR PART OF A MONTH.

PLEASE READ REVERSE SIDE
FOR IMPORTANT INFORMATION

MAKE CHECKS PAYABLE TO: WHITESIDE COUNTY COLLECTOR
200 EAST KNOX
MORRISON, IL 61270

RECEIPT PORTION - KEEP FOR YOUR RECORDS

Site Address

Owner's Name
WINNING WHEELS & ALS PLACE LTD

Legal Description
PT SE NW SEC 4 TWP 19 RNG 5 MF 10236-94 26402x

1ST DUE DATE	06/11/2010	2ND DUE DATE	09/03/2010
1ST INSTALLMENT	$153.76	2ND INSTALLMENT	$153.76
COSTS	INTEREST	COSTS	INTEREST
TOTAL PAID		TOTAL PAID	

STAMP PAID HERE
1ST INSTALLMENT

STAMP PAID HERE
2ND INSTALLMENT

TIF BASE	0
SAF BASE	0
TOTAL ACRES	1.02
LAND VALUE	3,405
+ BUILDING VALUE	0
-HOME IMPROVE EX	0
-DISABLED VET EX	0
= ASSESSED VALUE	3,405
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	3,405
- OWNER OCCUPIED EX	0
-SR CITIZEN EX	0
- SR ASMT FREEZE EX	0
- DIS VET HMSTD EX	0
-DISABLED PERSON EX	0
- RETURNING VET EX	0
+ FARM LAND	0
+ FARM BUILDING	0
=NET TAXABLE VAL.	3,405
x TAX RATE	9.0311
= CURRENT TAX	$307.52
+ DRAINAGE	$0.00
- ENTERPRISE ZONE	$0.00
= CURRENT TAX DUE	**$307.52**
- TOTAL TAX PAID	$0.00
= TOTAL TAX DUE	**$307.52**

32965

1st

PIN NUMBER 21-04-176-013	FORFEITED TAXES OR YEARS
	CURRENT TAX DUE $153.76
DUE DATE 06/11/2010	TAX PAYMENT - 1ST INST.
	COSTS / INTEREST
TOTAL ANNUAL TAX $307.52	TOTAL PAID

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

2nd

PIN NUMBER 21-04-176-013	FORFEITED TAXES OR YEARS
	CURRENT TAX DUE $153.76
DUE DATE 09/03/2010	TAX PAYMENT - 2ND INST.
	COSTS / INTEREST
TOTAL ANNUAL TAX $307.52	TOTAL PAID

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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).

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.

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	$ 377,675	$ 9,442	40	$ 9,442	$	$ 181,341	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIDEWALK & PATIO			1992	2,578	64	40	64		1,167	9
10	CARPET			1992	1,690		10			1,690	10
11	EMERGENCY LIGHTING			1992	723	18	40	18		344	11
12	MIXING VALVES			1992	1,840	46	40	46		878	12
13	LANDSCAPING TURF			1992	1,075	27	40	27		514	13
14	STORAGE SHED			1993	2,920	146	20	146		2,494	14
15	ROADWAY			1995	2,556	91	14	91		1,552	15
16	SIGN			1996	180	9	20	9		122	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		1,092	21
22	GARAGE			1997	36,165	1,447	25	1,447		18,565	22
23	SHOWER REMODEL			1998	3,322	166	20	166		2,076	23
24	CARPET			1998	1,753		5			1,753	24
25	BATHROOM TILE AND SHOWERS			1999	5,386	269	10	269		5,386	25
26	SIDEWALK			2000	1,113	56	20	56		552	26
27	PARKING LOT			2000	4,972	497	10	497		4,806	27
28	FRONT WALKWAY			2001	5,817	291	20	291		2,497	28
29	STEPS & SIDEWALKS TO PARKING LOT			2002	4,770	238	20	238		1,988	29
30	REMODEL ENTRY, LOUNGE, & NURSE STATION			2002	46,157	2,308	20	2,308		18,463	30
31	CARPET			2002	3,982	284	7	284		3,982	31
32	GRINDER PUMP			2005	4,270	285	15	285		1,447	32
33	HALL & OFFICE CARPET			2006	4,391	627	7	627		2,196	33
34	THERAPY ANNEX			2006	173,000	5,767	30	5,767		20,664	34
35	SIDEWALKS			2001	13,544	347	39	347		3,043	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 # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPING	2001	$ 8,745	$ 874	10	$ 874	$	$ 7,433	37
38	STEPS	2001	1,150	29	39	29		256	38
39	DRAINAGE & GRADING	2001	4,794	240	20	240		2,058	39
40	SLIDING POWER DOOR	2001	4,274	214	20	214		1,834	40
41	LEASEHOLD IMPROVEMENTS	2002	20,083	515	39	515		4,377	41
42	WINDOW TREATMENTS	2002	3,629		7			3,629	42
43	CARPET	2002	14,041		7			14,041	43
44	FENCING	2002	1,334	89	15	89		719	44
45	CARPET	2008	928	133	7	133		331	45
46	MAIN ENTRY TILE	2009	3,930	786	5	786		1,179	46
47	PARKING LOT PATCHING	2009	2,940	210	7	210		210	47
48	PAVILLION	2009	9,970	499	10	499		499	48
49	REPLACE WALL CARPET	2010	5,208	372	7	372		372	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)		$ 789,854	$ 26,466		$ 26,466	$	$ 322,891	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: 07/01/2009 Ending: 06/30/2010

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	$ 66,739	$ 8,594	$ 8,594	$	VARIOUS	$ 48,189	71
72	Current Year Purchases	8,907	636	636		VARIOUS	636	72
73	Fully Depreciated Assets	120,103					120,103	73
74								74
75	TOTALS	$ 195,749	$ 9,230	$ 9,230	$		$ 168,928	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	$ 5,387	$ 5,387	$	5	$ 53,867	76
77	RESIDENT OUTINGS	2009 FORD SHUTTLE BUS	2009	56,975	4,070	4,070		7	4,070	77
78										78
79										79
80	TOTALS			$ 110,842	$ 9,457	$ 9,457	$		$ 57,937	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)	$ 1,165,396	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,153	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,153	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)	$ 549,756	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	DESIGN WORK	$ 21,591	92
93			93
94			94
95		$ 21,591	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: 07/01/2009 Ending: 06/30/2010

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	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	TOTALS	$	$	$	$
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

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

(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.)

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

STATE OF ILLINOIS

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 250	$ 461,887	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0 / 41,709)	87,489	977,516	3
4	Supply Inventory (priced at)		43,770	4
5	Short-Term Investments		678,915	5
6	Prepaid Insurance		10,592	6
7	Other Prepaid Expenses		30,026	7
8	Accounts Receivable (owners or related parties)		1,152,040	8
9	Other(specify): ATTACHED		417,969	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 87,739	$ 3,772,715	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	319,861	13
14	Buildings, at Historical Cost	789,854	8,277,074	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	306,591	2,672,201	16
17	Accumulated Depreciation (book methods)	(549,756)	(6,107,048)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,634,591	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRE	21,591	69,199	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 637,231	$ 7,017,083	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 724,970	$ 10,789,798	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 80,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		247,778	30
31	Accrued Taxes Payable (excluding real estate taxes)		19,336	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
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE		109,715	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 457,397	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,540,658	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE		49,028	43
44	RESERVE FUND		2,767	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,592,453	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 2,049,850	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 724,970	$ 8,739,948	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 724,970	$ 10,789,798	48

***(See instructions.)**

STRIVE
415 A STREET FYE10
PROPHETSTOWN, IL 61277
IDPH #0036921

BALANCE SHEET PAGE 17

9	OTHER CURRENT ASSETS	
	Depoit in Frontier Hollow	$ 348,372
	Deposit in Pinnacle Place	97,601
	Investment in Al's Place Limited Partnership	(28,004)
	Consolidated Total	$ 417,969

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 840,820	1
2	Restatements (describe):		2
3	CONSOLIDATED BALANCES, BEGINNING OF YEAR	8,222,352	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,063,172	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,725	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) SUBSIDIARY COMPANIES		15
16	Other (describe) NET INCOME (LOSS)	(348,949)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (323,224)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,739,948	24 *

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,111,325	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,110,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	1,780	28
28a	MISCELLANEOUS	218	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,998	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,112,123	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	227,855	31
32	Health Care	463,578	32
33	General Administration	288,101	33
	B. Capital Expense		
34	Ownership	46,277	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,086,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,725	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,725	43

*** 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: 07/01/2009 Ending: 06/30/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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	1,877	2,089	32,886	15.74	10
11	Social Service Workers	1,912	2,080	37,416	17.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,230	2,398	28,991	12.09	14
15	Cook Helpers/Assistants	4,121	4,483	39,467	8.80	15
16	Dishwashers					16
17	Maintenance Workers	2,850	3,146	33,543	10.66	17
18	Housekeepers	1,217	1,321	10,291	7.79	18
19	Laundry	500	544	5,563	10.23	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,794	2,062	32,600	15.81	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)	25,906	28,615	327,612	11.45	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,407	46,738	$ 548,369 *	$ 11.73	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	$ 1,190	1.3	35
36	Medical Director	30	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	585	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) LAB	2	60	10.3	46
47	PSYCHOLOGICAL CONSULT	5	580	10a.3	47
48	HABILITATION AIDES	2,375	27,286	10.3	48
49	TOTAL (lines 35 - 48)	2,454	$ 32,701		49

C. CONTRACT NURSES

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMINISTRATOR		$
(SALARY INCLUDED IN MANAGEMENT			
FEES, LINE 17, COLUMN 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULTING	COMPUTER CONSULTIN(	$ 5,918
LINDGREN, CALLIHAN, VAN OSI	ACCOUNTING & AUDIT FEE	11,645
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE	600
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,163

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,063
Unemployment Compensation Insurance	
FICA Taxes	41,118
Employee Health Insurance	16,771
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DISABILITY & LIFE INSURANCE	6,713
PENSION	4,150
CHILD CARE	2,749
OTHER BENEFITS	6,215
DENTAL INSURANCE	1,340
TOTAL (agree to Schedule V, line 22, col.8)	$ 92,119

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	109
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
CARF	1,413
IHCA	839
NEWSPAPER SUBSCRIPTIONS	307
ATRA	125
NCTRC	80
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,873

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,417
Seminar Expense	1,436
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,853

**See instructions.

STRIVE - 0036921
Report Period Beginning – 7/1/2009
Report Period Ending – 6/30/2010
DETAIL SCHEDULE V-LINE 24

1		
Name & Title	Anne Dunbar, Administrator	
Dates of Seminar	7/28/2009	
Location	Springfield, IL	
Title	DD Symposium	
Sponsor	IHCA	
Cost		$ 100.00
2		
Names & Titles	Ginny Whitebread, Social Worker	
Dates of Seminar	8/13/2009	
Location	Arlington Heights, IL	
Title of Seminar	Needs for Adults with DD	
Sponsor	IARF	
Cost		$ 409.40
3		
Names & Titles	Anne Dunbar, Adminiatrator	
Date of Seminar	9/14/09-9/17/09	
Location	Peoria, IL	
Title	IHCA Annual Conference	
Sponsor	IHCA	
Cost		$ 595.16
4		
Name & Title	Anne Dunbar, Administrator Nancy Cummings, DT Coordinator	
Date Travel	12/16/2010	
Location	Moine, IL	
Title of Seminar	QMRP Conference	
Sponsor	ARC of IL	
Total Cost		$ 145.00
5		
Name & Title	Patty Page, Dietary Manager	
Date Travel	4/8-4/9/10	
Location	Rock Island, IL	
Title of Seminar	State Meeting	
Sponsor	IDMS	
Total Cost		$ 96.89
6		
Name & Title	Anne Dunbar, Administrator	
Dates of Seminar	6/2/2010	
Location	Springfield, IL	
Title	DD Symposium	
Sponsor	IHCA	
Cost		$ 90.00
Reimbursed Employee Travel & Mileage		$ 7,416.59
	Total	**$ 8,853.04**
	Agrees to Schedule V, Line 24	

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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 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? **6.67**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **453** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,587**
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. $
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: **WIPFLI LLP**

(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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.