FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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
IRS Exemption Code 501(c)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2010 to 06/30/2011 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) (Date) 12/13/2011

(Type or Print Name) MILT RUE

(Title) CFO

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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: 07/01/2010 Ending: 06/30/2011

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					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,756			5,756	13
14	TOTALS	5,756			5,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.56%

D. How many bed-hold days during this year were paid by the Department?
138 (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: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	67,760	6,075	900	74,735		74,735		74,735			1
2	Food Purchase		69,306		69,306		69,306		69,306			2
3	Housekeeping	16,773	6,908		23,681		23,681		23,681			3
4	Laundry	5,266	1,793		7,059		7,059		7,059			4
5	Heat and Other Utilities			16,045	16,045		16,045	(1,110)	14,935			5
6	Maintenance	40,371	14,719	10,795	65,885		65,885	2,100	67,985			6
7	Other (specify):*											7
8	**TOTAL General Services**	130,170	98,801	27,740	256,711		256,711	990	257,701			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	374,067	29,416	24,619	428,102		428,102		428,102			10
10a	Therapy							1,657	1,657			10a
11	Activities	44,596	5,384		49,980		49,980	2,336	52,316			11
12	Social Services	39,494			39,494		39,494		39,494			12
13	CNA Training											13
14	Program Transportation		4,338		4,338		4,338		4,338			14
15	Other (specify):* DENTAL SERVICES			2,340	2,340		2,340		2,340			15
16	**TOTAL Health Care and Programs**	458,157	39,138	29,959	527,254		527,254	3,993	531,247			16
	C. General Administration											
17	Administrative			121,998	121,998		121,998		121,998			17
18	Directors Fees											18
19	Professional Services			21,964	21,964		21,964		21,964			19
20	Dues, Fees, Subscriptions & Promotions			3,948	3,948		3,948	(816)	3,132			20
21	Clerical & General Office Expenses	34,718	10,641	3,482	48,841		48,841	19,085	67,926			21
22	Employee Benefits & Payroll Taxes			86,901	86,901		86,901	3,961	90,862			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,634	9,634		9,634		9,634			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,146	3,146		3,146		3,146			26
27	Other (specify):*											27
28	**TOTAL General Administration**	34,718	10,641	251,073	296,432		296,432	22,230	318,662			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	623,045	148,580	308,772	1,080,397		1,080,397	27,213	1,107,610			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:** 07/01/2010 **Ending:** 06/30/2011

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			46,697	46,697		46,697	(1,613)	45,084			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			311	311		311		311			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,008	47,008		47,008	(1,613)	45,395			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			60,193	60,193		60,193		60,193			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,193	60,193		60,193		60,193			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	623,045	148,580	415,973	1,187,598		1,187,598	25,600	1,213,198			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: 07/01/2010 Ending: 06/30/2011

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	(1,110)	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	(816)	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	4,480			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,554		$	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)	23,046		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 23,046		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 25,600		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: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEPRECIATION ON ITEMS UNDER $2,500	$ (1,613)	30	1
2	NEW IMPROVEMENT UNDER $2,500	1,073	6	2
3	NEW EQUIPMENT UNDER $2,500	1,657	10a	3
4	NEW EQUIPMENT UNDER $2,500	2,336	11	4
5	NEW EQUIPMENT UNDER $2,500	1,027	6	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**	4,480		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,110)	0	0	0	0	0	0	0	0	0	0	(1,110)	5
6	Maintenance	2,100	0	0	0	0	0	0	0	0	0	0	2,100	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	990	0	0	0	0	0	0	0	0	0	0	990	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	1,657	0	0	0	0	0	0	0	0	0	0	1,657	10a
11	Activities	2,336	0	0	0	0	0	0	0	0	0	0	2,336	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**	3,993	0	0	0	0	0	0	0	0	0	0	3,993	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	(816)	0	0	0	0	0	0	0	0	0	0	(816)	20
21	Clerical & General Office Expenses	0	19,085	0	0	0	0	0	0	0	0	0	19,085	21
22	Employee Benefits & Payroll Taxes	0	3,961	0	0	0	0	0	0	0	0	0	3,961	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**	(816)	23,046	0	0	0	0	0	0	0	0	0	22,230	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	4,167	23,046	0	0	0	0	0	0	0	0	0	27,213	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number STRIVE **#** 0036921 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(1,613)	0	0	0	0	0	0	0	0	0	0	(1,613)	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**	(1,613)	0	0	0	0	0	0	0	0	0	0	(1,613)	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)**	2,554	23,046	0	0	0	0	0	0	0	0	0	25,600	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC	100 %	WINNING WHEELS	PROPHETSTOWN	LYNDON PROGRESS CENTER	LYNDON	DAYTREATMENT REHABILITATION
				LYNDON PLAY & LEARN CENTER		CHILD DAYCARE
				FRONTIER HOLLOW APARTMENTS		INDEPENDENT LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 3,602	LYNDON PLAY & LEARN CENTER	0.00%	$ 5,363	$ 1,761	1
2	V								2
3	V								3
4	V		ADMINISTRATIVE OVERHEAD						4
5	V	21	CLERICAL SALARIES		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)		19,085	19,085	5
6	V	22	BENEFITS		(SEE DETAILS, SCHEDULE VIII, PAGE 8)		2,200	2,200	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,602			$ 26,648	$ * 23,046	14

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	0%	N/A		N/A			2
3	DAVID MICKLEY - VICE-PRESIDENT	0%	N/A		N/A			3
4	KYLE GIBSON - TREASURER	0%	N/A		N/A			4
5	MARY ANN HILL - SECRETARY	0%	N/A		N/A			5
6	MEREDITH HAMMER	0%	N/A		N/A			6
7	CONNIE DEMARANVILLE	0%	N/A		N/A			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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 07/01/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: WINNING WHEELS ADMINISTRATIVE FUNI
Street Address: 501 6TH AVE W
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3610
Fax Number: (815-778-4503

	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	21	ADMINISTRATIVE SALARIES	SALARIES/BENEFITS	6,332,151	7	$ 170,257	$ 170,257	709,806	$ 19,085	1
2	22	FICA	SALARIES/BENEFITS	6,332,151	7	9,969		709,806	1,117	2
3	22	LIFE INSURANCE	SALARIES/BENEFITS	6,332,151	7	409		709,806	46	3
4	22	HEALTH INSURANCE	SALARIES/BENEFITS	6,332,151	7	3,051		709,806	342	4
5	22	403 B RETIREMENT	SALARIES/BENEFITS	6,332,151	7	1,588		709,806	178	5
6	22	DENTAL INSURANCE	SALARIES/BENEFITS	6,332,151	7	290		709,806	33	6
7	22	ST & LT DISABILITY INSURAN	SALARIES/BENEFITS	6,332,151	7	1,500		709,806	168	7
8	22	CHILD CARE	SALARIES/BENEFITS	6,332,151	7	2,328		709,806	261	8
9	22	OTHER	SALARIES/BENEFITS	6,332,151	7	489		709,806	55	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					$ 189,881	$ 170,257		$ 21,285	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	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:** 07/01/2010 **Ending:** 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 308	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.)		$ 311	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3	3
4. Real Estate Tax accrual used for 2011 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.		$ 311	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	274	8
2007	282	9
2008	304	10
2009	308	11
2010	311	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT MILT 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 2010 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 2010.

	(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	$ 310.72	$ 310.72
2.		5 MF 10236-94 26402x	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 310.72	$ 310.72

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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
DARLENE HOOK, COUNTY TREASURER
200 EAST KNOX
MORRISON, IL 61270

WHITESIDE COUNTY PROPERTY TAX BILL
2010 TAXES PAYABLE 2011

Make checks payable to: WHITESIDE COUNTY COLLECTOR

LEGAL DESC:
PT SE NW SEC 4 TWP 19 RNG 5 MF 10236-94
26402x

PROPERTY INDEX NUMBER (PIN)	21-04-176-013
FIRST DUE DATE	06/10/2011
FIRST INSTALLMENT	$155.36
SECOND DUE DATE	09/02/2011
SECOND INSTALLMENT	$155.36
PRIOR TAX SOLD	NO
FORFEITED	NO

NAME:
015998
WINNING WHEELS
701 E 3RD ST
PROPHETSTOWN, IL 61277-1334

STAMP PAID HERE
1st INSTALLMENT

STAMP PAID HERE
2nd INSTALLMENT

TAX CODE		TOWNSHIP	PROPERTY CLASS
02005	WHITESIDE COUNTY ITEMIZED STATEMENT	Prophetstown	1023

Taxing Body	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Difference Amount	Pension Amount	Library Amount
WHITESIDE COUNTY	1.0867	$37.02	1.1141	$38.25	$1.23	$12.80	$0.00
PROPHETSTOWN FIRE	0.4117	$14.02	0.4203	$14.43	$0.41	$0.00	$0.00
SAUK VALLEY NO 506	0.4421	$15.05	0.4433	$15.22	$0.17	$0.00	$0.00
PROPHETSTOWN PARK	0.4251	$14.47	0.4204	$14.43	($0.04)	$0.88	$0.00
PROPHETSTOWN TOWNSHIP	0.3760	$12.80	0.3681	$12.64	($0.16)	$0.00	$0.00
PROPHETSTOWN TOWNSHIP ROAD	0.5360	$18.25	0.5361	$18.40	$0.15	$0.00	$0.00
PTOWN-LYN-TAMP UNIT #3	4.7914	$163.15	4.7643	$163.56	$0.41	$12.42	$0.00
PROPHETSTOWN CITY	0.9621	$32.76	0.9842	$33.79	$1.03	$15.25	$4.23
TOTAL	9.0311	$307.52	9.0508	$310.72	$3.20	$41.35	$4.23

SITE ADDRESS:

Owner Name: WINNING WHEELS

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

TIF BASE	0
SAF BASE	0
MARKET VALUE	10,299
TOTAL ACRES	1.02
LAND VALUE	3,433
+ BUILDING VALUE	0
-HOME IMPROVEMENT EX	0
- DISABLED VET EX	0
= ASSESSED VALUE	3,433
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	3,433
- OWNER OCCUPIED EX	0
- SR CITIZEN EX	0
- SR ASMT FREEZE EX	0
- DISABLED VET HMSTD EX	0
- DISABLED PERSON EX	0
- RETURNING VET EX	0
+ FARM LAND	0
+ FARM BUILDING	0
= NET TAXABLE VAL.	3,433
x TAX RATE	9.0508
= CURRENT TAX	$310.72
- ENTERPRISE ZONE	$0.00
+ DRAINAGE	$0.00
= TOTAL TAX DUE	$310.72

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 190,783	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1992	7,906	155	34	155		4,749	9
10	REMODELING			1993	2,920	146	20	146		2,640	10
11	REMODELING			1995	2,556	182	14	182		1,734	11
12	REMODELING			1996	1,805	9	15	9		1,757	12
13	REMODELING			1997	43,489	1,527	15	1,527		26,900	13
14	REMODELING			1998	5,075	166	12.5	166		3,995	14
15	REMODELING			1999	5,387		10			5,386	15
16	REMODELING			2000	6,085	221	15	221		5,579	16
17	REMODELING			2001	38,324	1,996	26.74	1,996		19,116	17
18	REMODELING			2002	93,996	3,150	16.43	3,150		50,348	18
19	REMODELING			2005	4,270	285	15	285		1,732	19
20	REMODELING			2006	177,392	6,394	18.5	6,394		29,253	20
21	CARPET			2008	928	133	7	133		464	21
22	TILE MAIN ENTRY			2009	3,930	786	5	786		1,965	22
23	PATCH WORK IN PARKING LOT			2009	2,940	420	7	420		630	23
24	PAVILLION - OUTDOOR COVERED PATIO			2009	9,970	997	10	997		1,496	24
25	REPLACE WALL CARPET			2010	5,208	744	7	744		1,116	25
26	ROOF ON MAIN BUILDING			2010	16,654	1,110	15	1,110		1,110	26
27											27
28											28
29	DEFERRED MAINTENANCE ITEMS CAPITALIZED				10,949	317	7	317		6,828	29
30	(SEE PAGE 22)										30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			$	$		$	$	$	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)		$ 817,459	$ 28,180		$ 28,180	$	$ 357,581	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: 07/01/2010 Ending: 06/30/2011

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	$ 62,940	$ 8,475	$ 8,475	$	8	$ 44,594	71
72	Current Year Purchases	2,896	290	290		5	290	72
73	Fully Depreciated Assets	132,809					132,809	73
74								74
75	TOTALS	$ 198,645	$ 8,765	$ 8,765	$		$ 177,693	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	$ 53,867	$	$	$	5	$ 53,867	76
77	RESIDENT OUTINGS	2009 FORD SHUTTLE BUS	2009	56,975	8,139	8,139		7	12,209	77
78										78
79										79
80	TOTALS			$ 110,842	$ 8,139	$ 8,139	$		$ 66,076	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)	$ 1,195,897	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,084	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,084	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)	$ 601,350	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: 07/01/2010 Ending: 06/30/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: 07/01/2010 Ending: 06/30/2011

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
   - [X] 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.

Facility Name & ID Number STRIVE

STATE OF ILLINOIS
0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011 (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	$ 52,600	$ 219,629	1
2	Cash-Patient Deposits	2,993	23,533	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0 / 24,182)	175,902	447,872	3
4	Supply Inventory (priced at COST)	11,790	42,149	4
5	Short-Term Investments		22,486	5
6	Prepaid Insurance		7,065	6
7	Other Prepaid Expenses		25,246	7
8	Accounts Receivable (owners or related parties)		2,191,849	8
9	Other(specify): PG17_SUPPORT		446,472	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 243,285	$ 3,426,301	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	231,451	13
14	Buildings, at Historical Cost	810,390	7,513,417	14
15	Leasehold Improvements, at Historical Cost		43,361	15
16	Equipment, at Historical Cost	317,451	2,352,722	16
17	Accumulated Depreciation (book methods)	(604,033)	(5,485,950)	17
18	Deferred Charges	10,949	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,731,431	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRES	21,591	148,921	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 625,299	$ 6,568,468	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 868,584	$ 9,994,769	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 63,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,993	23,533	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		209,721	30
31	Accrued Taxes Payable (excluding real estate taxes)		10,714	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		560	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE		2,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,993	$ 310,112	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,503,580	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE		7,691	43
44	RESERVE FUND		2,419	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,513,690	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,993	$ 1,823,802	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 865,591	$ 8,170,967	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 868,584	$ 9,994,769	48

***(See instructions.)**

STRIVE
415 A STREET FYE 2011
PROPHETSTOWN, IL 61277
IDPH #0036921

BALANCE SHEET PAGE 17

9	OTHER CURRENT ASSETS	
	Depoit in Frontier Hollow	$ 388,464
	Deposit in Pinnacle Place	97,601
	Investment in Al's Place Limited Partnership	(39,593)
	Consolidated Total	$ 446,472

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,739,948	1
2	Restatements (describe):		2
3			3
4	ADJUST TO AUDITED FUND BALANCE	(270,298)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,469,650	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(87,351)	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) CONSOLIDATED ENTITIES		15
16	Other (describe) NET INCOME (LOSS)	(211,332)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (298,683)	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)**	$ 8,170,967	24 *

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 1,094,795	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,093,595	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	6,652	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,652	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,100,247	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	256,711	31
32	Health Care	527,254	32
33	General Administration	296,432	33
	B. Capital Expense		
34	Ownership	47,008	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,193	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,187,598	40
41	**Income before Income Taxes (line 30 minus line 40)****	(87,351)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (87,351)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 07/01/2010 Ending: 06/30/2011

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	1,413	1,465	22,773	15.54	9
10	Activity Assistants	1,494	1,754	21,823	12.44	10
11	Social Service Workers	1,973	2,109	39,494	18.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,875	2,165	27,085	12.51	14
15	Cook Helpers/Assistants	3,265	3,577	40,675	11.37	15
16	Dishwashers					16
17	Maintenance Workers	2,583	2,826	40,371	14.29	17
18	Housekeepers	1,745	1,871	16,773	8.96	18
19	Laundry	499	552	5,266	9.54	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,884	2,100	34,718	16.53	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)	29,041	31,887	374,067	11.73	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	45,772	50,306	$ 623,045 *	$ 12.39	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	23	$ 900	1.3	35
36	Medical Director	30	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	4	198	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) DENTAL SERVICES	29	2,340	15.3	46
47	PSYCHOLOGICAL CONSULT	5	650	10.3	47
48					48
49	TOTAL (lines 35 - 48)	91	$ 7,088		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	172	4,459	10.3	51
52	Certified Nurse Assistants/Aides	892	12,426	10.3	52
53	TOTAL (lines 50 - 52)	1,064	$ 16,885		53

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMINISTRATOR		$
(SALARY INCLUDED WITH			
AMERICAN HEALTH ENTERPRISES)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 121,998
TOTAL (agree to Schedule V, line 17, col. 3)	$ 121,998
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULTING	COMPUTER CONSULTIN	$ 6,994
WIPFLI, LLC	ANNUAL AUDIT FEES	12,945
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE	600
MARTIN, HOOD, FRIESE, & ASSC	403(b) AUDIT FEES	1,425
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,964

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	47,746
Employee Health Insurance	18,479
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	2,088
RETIREMENT	5,253
DENTAL SERVICES	1,363
DISABILITY	4,945
CHILDCARE	5,624
OTHER BENEFITS	5,364
TOTAL (agree to Schedule V, line 22, col.8)	$ 90,862

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	575
Health Care Worker Background Check	30
(Indicate # of checks performed)	
Patient Background Checks	
CARF	1,413
IHCA	420
NEWSPAPERS	381
ASSOCIATION DUES	278
ADVERTISING / COMM. RELATIONS	816
Less: Public Relations Expense	(270)
Non-allowable advertising	(546)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,132

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,224
Seminar Expense	1,410
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,634

* Attach copy of IMRF notifications

**See instructions.

STRIVE - 0036921
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

1			
Name & Title	Toni Williar, TR Activity Director		
Dates of Seminar	10/28/10 - 10/29/10		
Location	Arlington Heights, IL		
Title	Activity Conference		
Sponsor	IAPA		
Cost		$	508.00
2			
Names & Titles	Toni Williar, TR Activity Director		
	Geri Lundquist, TR Assistant		
Dates of Seminar	11/4/2010		
Location	Galesburg, IL		
Title of Seminar	Restorative Nursning Asst.		
Sponsor	Azer Seminars		
Cost		$	340.00
3			
Names & Titles	Anne Dunbar, Adminiatrator		
	Nancy Cummings, DT Coordinator		
Date of Seminar	1/25/2011		
Location	Alsip, IL		
Title	QSP Leadership		
Sponsor	ARC of IL		
Cost		$	451.97
4			
Name & Title	Rachel Armstrong, Cook		
Date Travel	3/26/2011		
Location	Sterling, IL		
Title of Seminar	Food Service Cert. Seminar		
Sponsor	CGH Medical Center		
Total Cost		$	110.00
Reimbursed Employee Travel & Mileage		$	8,223.83
	Total	**$**	**9,633.80**

Agrees to Schedule V, Line 24

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	PAINTING	07/2001	$ 1,205	5	$	$	$	$	$	$	$	$	$
2	PAINTING	09/2001	3,040	5									
3	PAINTING	06/2002	743	5	74								
4	PAINTING	08/2002	1,523	5	305								
5	PAINTING	06/2011	3,196	7					228	457	457	457	457
6	FLOORING	06/2011	1,242	7					89	177	177	177	177
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,949		$ 379	$	$	$	$ 317	$ 634	$ 634	$ 634	$ 634

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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? **8.25**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **413** 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. $ **60,193**
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?
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 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.