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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROBIN JACKSON **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 07/01/2015 to 06/30/2016 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)
(Type or Print Name) Robin Jackson
(Title) Chief Financial Officer

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: 07/01/2015 Ending: 06/30/2016

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 16

	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	16	Intermediate/DD	16	5,856	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	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	5,716			5,716	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,716			5,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.61%

D. How many bed-hold days during this year were paid by the Department?
117 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 [ ] NO [ ]

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

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	71,690	5,062	1,170	77,922		77,922		77,922			1
2	Food Purchase		49,298		49,298		49,298		49,298			2
3	Housekeeping	40,931	6,456		47,387		47,387		47,387			3
4	Laundry	4,079	3,613		7,692		7,692		7,692			4
5	Heat and Other Utilities			19,110	19,110		19,110	(560)	18,550			5
6	Maintenance	41,018	8,870	12,126	62,014		62,014		62,014			6
7	Other (specify):*											7
8	**TOTAL General Services**	157,718	73,299	32,406	263,423		263,423	(560)	262,863			8
	B. Health Care and Programs											
9	Medical Director			1,525	1,525		1,525		1,525			9
10	Nursing and Medical Records	361,423	27,267	21,226	409,916	(5,855)	404,061		404,061			10
10a	Therapy			1,512	1,512		1,512		1,512			10a
11	Activities	57,345	2,529		59,874		59,874		59,874			11
12	Social Services	46,074			46,074		46,074		46,074			12
13	CNA Training											13
14	Program Transportation		2,352		2,352	(1,176)	1,176		1,176			14
15	Other (specify):* DENTAL			1,755	1,755		1,755		1,755			15
16	**TOTAL Health Care and Programs**	464,842	32,148	26,018	523,008	(7,031)	515,977		515,977			16
	C. General Administration											
17	Administrative			129,665	129,665		129,665		129,665			17
18	Directors Fees											18
19	Professional Services			19,431	19,431		19,431		19,431			19
20	Dues, Fees, Subscriptions & Promotions			1,906	1,906		1,906	(264)	1,642			20
21	Clerical & General Office Expenses	39,110	6,463	5,748	51,321		51,321	22,459	73,780			21
22	Employee Benefits & Payroll Taxes			107,654	107,654		107,654	2,767	110,421			22
23	Inservice Training & Education											23
24	Travel and Seminar			701	701		701		701			24
25	Other Admin. Staff Transportation			9,154	9,154		9,154		9,154			25
26	Insurance-Prop.Liab.Malpractice			4,223	4,223		4,223		4,223			26
27	Other (specify):*											27
28	**TOTAL General Administration**	39,110	6,463	278,482	324,055		324,055	24,962	349,017			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	661,670	111,910	336,906	1,110,486	(7,031)	1,103,455	24,402	1,127,857			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: 07/01/2015 Ending: 06/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			43,823	43,823	(4,090)	39,733		39,733			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,132	4,132		4,132		4,132			32
33	Real Estate Taxes			301	301		301		301			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			48,256	48,256	(4,090)	44,166		44,166			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					11,121	11,121		11,121			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,567	65,567		65,567		65,567			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,567	65,567	11,121	76,688		76,688			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	661,670	111,910	450,729	1,224,309		1,224,309	24,402	1,248,711			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: 07/01/2015 Ending: 06/30/2016

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	(560)	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	(264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (824)		$	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)	25,226	21, 22	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 25,226		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 24,402		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.		xx	$ 11,121	14.2	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 11,121		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Lyndon Progress Center (LPC)
For The 12 Periods Ended 6/30/2016
90 ADMINISTRATION

EXPENSES			Wheels	STRIVE
5460-90	ADMINISTRATION	$ 177,305.67	$ 97,005.00	$ 22,459.00
6460-90	ADMINISTRATIVE	$ 40,635.00		
5620-90	FICA	$ 13,308.46	$ 5,924.00	$ 1,371.00
5640-90	WORKMAN'S COMP	$ 5,333.82	$ 2,374.00	$ 550.00
5660-90	LIFE INSURANCE	$ 459.96	$ 205.00	$ 47.00
5665-90	VISION INSURANCE	$ 170.28	$ 76.00	$ 18.00
5670-90	HEALTH INSURANCE	$ 1,292.04	$ 575.00	$ 133.00
5671-90	HEALTH INSURANCE	$ 1,750.00	$ 779.00	$ 180.00
5675-90	SUPPLEMENTAL INS	$ 642.24	$ 286.00	$ 66.00
5685-90	DENTAL INSURANCE	$ 773.76	$ 344.00	$ 80.00
5690-90	ST & LT DISABILITY INS	$ 870.72	$ 388.00	$ 90.00
5695-90	VOL LIFE INS	$ 88.77	$ 40.00	$ 9.00
5730-90	CHILD CARE	$ 1,317.50	$ 586.00	$ 136.00
5750-90	OTHER	$ 847.48	$ 377.00	$ 87.00
Total EXPENSES:		$ 244,795.70	$ 108,959.00	$ 25,226.00

		% of Total Salaries and Benefits	Portion of LPC Salaries and Benefits
Winning Wheels			
Salaries	$ 2,871,750.94		$ 97,005.33
Benefits	$ 467,604.55		$ 11,953.17
Total Salaries and Benefits	$ 3,339,355.49	44.51%	$ 108,958.50
STRIVE			
Salaries	$ 661,669.41		$ 22,458.94
Benefits	$ 111,467.37		$ 2,767.43
Total Salaries and Benefits	$ 773,136.78	10.31%	$ 25,226.37
Day Treatment			
Salaries	$ 212,994.08		$ 7,225.89
Benefits	$ 35,753.09		$ 890.39
Total Salaries and Benefits	$ 248,747.17	3.32%	$ 8,116.28
Frontier Hollow			
Salaries	$ 187,822.58		$ 6,310.28
Benefits	$ 29,405.48		$ 777.56
Total Salaries and Benefits	$ 217,228.06	2.90%	$ 7,087.84
Day Care			
Salaries	$ 166,602.53		$ 5,687.17
Benefits	$ 29,175.06		$ 700.78
Total Salaries and Benefits	$ 195,777.59	2.61%	$ 6,387.95
Pinnacle Place			
Salaries	$ 224,419.77		$ 7,659.10
Benefits	$ 39,240.64		$ 943.77
Total Salaries and Benefits	$ 263,660.41	3.51%	$ 8,602.87
Big Meadows			
Salaries	$ 2,136,857.11		$ 71,593.95
Benefits	$ 327,725.28		$ 8,821.93
Total Salaries and Benefits	$ 2,464,582.39	32.85%	$ 80,415.88
Total			
Salaries	$ 6,462,116.42		**$ 217,940.66**
Benefits	$ 1,040,371.47		**$ 26,855.03**
Total Salaries and Benefits	**$ 7,502,487.89**	**100.00%**	**$ 244,795.69**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	(560)	0	0	0	0	0	0	0	0	0	0	(560)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(560)	0	0	0	0	0	0	0	0	0	0	(560)	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	(264)	0	0	0	0	0	0	0	0	0	0	(264)	20
21	Clerical & General Office Expenses	0	22,459	0	0	0	0	0	0	0	0	0	22,459	21
22	Employee Benefits & Payroll Taxes	0	2,767	0	0	0	0	0	0	0	0	0	2,767	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**	(264)	25,226	0	0	0	0	0	0	0	0	0	24,962	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(824)	25,226	0	0	0	0	0	0	0	0	0	24,402	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE **#** 0036921 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(824)	25,226	0	0	0	0	0	0	0	0	0	24,402	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Winning Wheels	100	Winning Wheels	Prophetstown	Lyndon Progress Center	Lyndon	Day Treatment
				Lyndon Play & Learn Center	Lyndon	Child Care
				Frontier Hollow Apartments	Prophetstown	Independent Living Facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V		Administrative Overhead						5
6	V	21	Clerical Salaries		Winning Wheels Inc (Administrative Fund)		22,459	22,459	6
7	V	22	Benefits		(See details, schedule VIII, Page 8)		2,767	2,767	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 25,226	$ * 25,226	14

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors							1
2	John Guzzardo - President	0						2
3	David Mickely	0						3
4	Connie Demaranville	0						4
5	Bill Sullivan	0						5
6	Kyle Gibson	0						6
7	Meredith Hammer	0						7
8	Mary Ann Hill	0						8
9	Rick Turnroth	0						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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: 07/01/2015 Ending: 6/30/2016

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 Fund
Street Address: 501 6th Ave West
City / State / Zip Code: Lyndon, IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 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	CLERICAL SALARIES	SALARIES/BENEFITS	7,502,488	7	$ 217,941	$ 217,941	773,137	$ 22,459	1
2	22	FICA	SALARIES/BENEFITS	7,502,488	7	13,308		773,137	1,371	2
3	22	WORKERS COMP	SALARIES/BENEFITS	7,502,488	7	5,334		773,137	550	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	7,502,488	7	460		773,137	47	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	7,502,488	7	3,042		773,137	313	5
6	22	VISION INSURANCE	SALARIES/BENEFITS	7,502,488	7	170		773,137	18	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	7,502,488	7	774		773,137	80	7
8	22	ST & LT DISABILITY INS	SALARIES/BENEFITS	7,502,488	7	1,602		773,137	165	8
9	22	CHILD CARE	SALARIES/BENEFITS	7,502,488	7	1,318		773,137	136	9
10	22	OTHER	SALARIES/BENEFITS	7,502,488	7	847		773,137	87	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					$ 244,796	$ 217,941		$ 25,226	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	FARMERS NATIONAL BANK		X	LINE OF CREDIT	YES	3-10-14	250,000	202,118	3-14-19	0.0395	4,132	6
7												7
8												8
9	TOTAL Facility Related						$ 250,000	$ 202,118			$ 4,132	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 250,000	$ 202,118			$ 4,132	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: 07/01/2015 Ending: 06/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 301	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.)		$ 301	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	316	8
	2012	320	9
	2013	321	10
	2014	291	11
	2015	301	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT Robin Jackson

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

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-04-176-013	PRT SE NW SEC 4 TWP 19 RNG	$ 300.56	$ 300.56
2.		5MR 10236-94-26402X	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 300.56	$ 300.56

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

FRONTIER HOLLOW APARTMENTS, INDEPENDENT LIVING APARTMENTS 16 ONE BEDROOM UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	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: 07/01/2015 Ending: 06/30/2016

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	$	$ 237,993	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1992	7,906	155	34	155		5,525	9
10	REMODELING			1993	2,920		20			2,920	10
11	REMODELING			1995	2,556	183	14	183		5,021	11
12	REMODELING			1997	43,489	1,527	15	1,527		34,535	12
13	REMODELING			1998	5,075	166	12.5	166		4,825	13
14	REMODELING			1999	5,386		10			5,386	14
15	REMODELING			2000	6,085	56	15	56		5,859	15
16	REMODELING			2001	42,569	1,121	21.89	1,121		29,403	16
17	REMODELING			2002	96,262	3,150	13	3,150		68,364	17
18	REMODELING			2005	4,270	285	15	285		3,156	18
19	REMODELING			2006	177,391	6,080	18.5	6,080		60,282	19
20	REMODELING			2008	928	133	7	133		1,127	20
21	REMODELING			2009	16,840	1,810	7.33	1,810		13,927	21
22	REPLACE WALL CARPET THROUGHOUT BUILDING			2010	5,208	744	7	744		4,836	22
23	ROOF ON MAIN BUILDING			2010	16,654	1,110	15	1,110		6,661	23
24	PAINTING MAIN HALLWAY AND DINING ROOM			2011	3,196	457	7	457		2,512	24
25	FLOORING AND WALL CARPET IN MAIN HALLWAYS			2012	5,212	1,042	5	1,042		4,690	25
26	CARPET IN FOUR RESIDENT ROOMS			2012	4,101	586	7	586		2,637	26
27	WIRING FOR GENERATOR PREPARATION			2014	10,750	1,536	7	1,536		3,328	27
28											28
29	REMODELING			1996	1,805	9	15	9		1,802	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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)		$ 836,278	$ 29,592		$ 29,592	$	$ 504,789	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: 07/01/2015 Ending: 06/30/2016

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	$ 63,063	$ 5,532	$ 5,532	$	7.12	$ 40,625	71
72	Current Year Purchases	6,697	560	560	(0)	7	560	72
73	Fully Depreciated Assets	181,237				8.75	181,237	73
74								74
75	TOTALS	$ 250,997	$ 6,092	$ 6,092	$ (0)		$ 222,422	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	2009 FORD SHUTTLE BUS	2009	$ 56,975	$ 8,139	$ 4,049	$ (4,090)	7	$ 52,905	76
77	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	53,867				5	53,867	77
78										78
79										79
80	TOTALS			$ 110,842	$ 8,139	$ 4,049	$ (4,090)		$ 106,772	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)	$ 1,267,068	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,823	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,733	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,090)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 833,983	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 07/01/2015 Ending: 06/30/2016

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 [xx] 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	10a.3	hrs		494	1,109		494	1,109	4
5	Physician Care		visits							5
6	Dental Care	15.3	visits		22	1,755		22	1,755	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10.3	# of prescrpts		10	683		10	683	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICARE THERAP	10a.3			179	403		179	403	12
13	Other (specify): PHYSIATRIAN	9.3			12	1,525		12	1,525	13
14	TOTAL			$	717	$ 5,475	$	717	$ 5,475	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:** 07/01/2015 **Ending:** 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2016 **(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	$ 57,950	$ 475,328	1
2	Cash-Patient Deposits	1,804	31,020	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	89,388	874,256	3
4	Supply Inventory (priced at COST)	11,513	44,450	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,150	17,673	6
7	Other Prepaid Expenses	4,724	60,308	7
8	Accounts Receivable (owners or related parties)		974,207	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 166,529	$ 2,477,242	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	359,361	13
14	Buildings, at Historical Cost	836,278	15,080,919	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	361,839	3,463,420	16
17	Accumulated Depreciation (book methods)	(833,983)	(8,318,678)	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		554,770	21
22	Other Long-Term Assets (specify):		9,061	22
23	Other(specify):		266	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 444,034	$ 11,182,234	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 610,563	$ 13,659,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 122,198	$ 819,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,804	44,831	28
29	Short-Term Notes Payable	202,118	2,322,650	29
30	Accrued Salaries Payable	31,884	344,321	30
31	Accrued Taxes Payable (excluding real estate taxes)		74,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)	301	39,753	32
33	Accrued Interest Payable		57,080	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKERS COMP		25,388	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 358,305	$ 3,728,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,706,024	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE		49,029	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,755,053	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 358,305	$ 9,483,323	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 252,258	$ 4,176,153	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 610,563	$ 13,659,476	48

***(See instructions.)**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,581,574	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,581,574	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(82,521)	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) NET LOSS	(322,900)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (405,421)	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)**	$ 4,176,153	24 *

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,125,425	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,124,225	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,352	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,352	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	11,121	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,121	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,137,698	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	263,423	31
32	Health Care	523,008	32
33	General Administration	324,055	33
	B. Capital Expense		
34	Ownership	44,166	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,567	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,220,219	40
41	**Income before Income Taxes (line 30 minus line 40)****	(82,521)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (82,521)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,124,225	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,124,225	49

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

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

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

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

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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	1,774	2,002	35,107	17.54	9
10	Activity Assistants	1,724	1,916	22,238	11.61	10
11	Social Service Workers	1,900	2,080	46,074	22.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,921	2,126	30,761	14.47	14
15	Cook Helpers/Assistants	3,760	3,961	40,929	10.33	15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,133	41,018	19.23	17
18	Housekeepers	3,080	3,364	40,931	12.17	18
19	Laundry	420	420	4,079	9.71	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,770	2,066	39,110	18.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	24,376	27,501	361,423	13.14	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,732	47,569	$ 661,670 *	$ 13.91	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	31	$ 1,170	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	683	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	22	1,755	15.3	46
47	PHYSIATRIAN	12	1,525	9.3	47
48					48
49	TOTAL (lines 35 - 48)	76	$ 5,133		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	513	14,876	10.3	51
52	Certified Nurse Assistants/Aides	213	2,667	10.3	52
53	TOTAL (lines 50 - 52)	726	$ 17,543		53

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMIN	0	$ 80,321
(INCLUDED IN AMERICAN HEALTH			
ENTERPRISES IN B BELOW)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,321

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 129,665
TOTAL (agree to Schedule V, line 17, col. 3)	$ 129,665
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RELIAS	SOFTWARE FEES	$ 1,572
JOHN PYSE CONSULT	IT CONSULTANT	3,331
MIDWEST AUTOMATED	TIME CLOCK SOFTWARE	880
MARCUM	AUDIT / 990 RETURN	9,250
CAREVOYANT	MDS SOFTWARE	3,983
SOFTWARE CONSULTANT	SOFTWARE FEES	415
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 19,431

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,718
Unemployment Compensation Insurance	3,696
FICA Taxes	51,291
Employee Health Insurance	13,007
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	2,767
DISABILITY INS	4,147
CHILD CARE	901
PROF LICENSE AND TRAINING	258
DENTAL / VISION INSURANCE	2,663
OTHER	349
5 YEAR BANQUET / XMAS GIFT	5,857
TOTAL (agree to Schedule V, line 22, col.8)	$ 107,654

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	582
Health Care Worker Background Check	
(Indicate # of checks performed 2)	100
Patient Background Checks	
COMMUNITY RELATIONS	264
IHCA DUES	960
Less: Public Relations Expense	(264)
Non-allowable advertising	( )
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,642

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	186
Seminar Expense	515
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 701

**See instructions.

STRIVE 36921

Report Period Beginning 7/1/15

Report Period Ending 6/30/16

		DETAIL SCHEDULE - V-LINE 24	In State	Out of State
1	Name & Title	Toni Williar		
	Date of Seminar	09/23/15 - 09/24/15		
	Location	Arlington		
	Title of Seminar	2015 IAPA Conference		
	Sponsor	IAPA - Il Activity Professional Association		
	Cost	$434.36	$421.24	
3	Name & Title	Anne Dunbar, Administrator Nancy Cummings, Day Treament Coordinator		
	Date of Seminar	1/27/2016		
	Location	Alsip, IL		
	Title of Seminar	QIDP Conference - Qualified Intellectual Disabilities Professional		
	Sponsor	The Arc of IL		
	Cost	$360.00	$280.00	
			$701.24	$0.00

Total Seminars	$701.24
Less: Out of State Travel & Seminars	$0.00
Total Travel and Seminars	$701.24
Total - Schedule V, Line 24 - Other	$701.24
Total - Schedule V, Line 24 - Adjustments	$0.00

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $960**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,858** 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 **NO** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **65,567**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **YES** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **11,121**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **MARCUM**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees