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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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©3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Robin Landis **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 07/01/2016 to 06/30/2017 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 Landis

(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: 07/01/2016 Ending: 06/30/2017

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	16	Intermediate/DD	16	5,840	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,638			5,638	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,638			5,638	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.54%

D. How many bed reserve days during this year were paid by the Department?
83 (Do not include bed reserve 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: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	68,456	4,642	1,236	74,334		74,334		74,334			1
2	Food Purchase		43,034		43,034		43,034		43,034			2
3	Housekeeping	31,728	7,477		39,205		39,205		39,205			3
4	Laundry	3,580	2,782		6,362		6,362		6,362			4
5	Heat and Other Utilities			22,476	22,476		22,476	(560)	21,916			5
6	Maintenance	40,233	14,118	12,869	67,220		67,220		67,220			6
7	Other (specify):*											7
8	**TOTAL General Services**	143,997	72,053	36,581	252,631		252,631	(560)	252,071			8
	B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600			9
10	Nursing and Medical Records	368,465	29,012	18,732	416,209	(2,706)	413,503		413,503			10
10a	Therapy			4,361	4,361		4,361		4,361			10a
11	Activities	58,800	2,761		61,561		61,561		61,561			11
12	Social Services	45,501			45,501		45,501		45,501			12
13	CNA Training											13
14	Program Transportation		2,195		2,195	(1,176)	1,019		1,019			14
15	Other (specify):* DENTAL			2,925	2,925		2,925		2,925			15
16	**TOTAL Health Care and Programs**	472,766	33,968	28,618	535,352	(3,882)	531,470		531,470			16
	C. General Administration											
17	Administrative			128,331	128,331		128,331		128,331			17
18	Directors Fees											18
19	Professional Services			18,697	18,697		18,697		18,697			19
20	Dues, Fees, Subscriptions & Promotions			1,411	1,411		1,411	(288)	1,123			20
21	Clerical & General Office Expenses	40,083	5,825	1,803	47,711		47,711	21,847	69,558			21
22	Employee Benefits & Payroll Taxes			108,647	108,647		108,647	2,701	111,348			22
23	Inservice Training & Education			371	371		371		371			23
24	Travel and Seminar			1,343	1,343		1,343		1,343			24
25	Other Admin. Staff Transportation			4,970	4,970		4,970		4,970			25
26	Insurance-Prop.Liab.Malpractice			4,123	4,123		4,123		4,123			26
27	Other (specify):*											27
28	**TOTAL General Administration**	40,083	5,825	269,696	315,604		315,604	24,260	339,864			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	656,846	111,846	334,895	1,103,587	(3,882)	1,099,705	23,700	1,123,405			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: 07/01/2016 Ending: 06/30/2017

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			37,192	37,192	(7,896)	29,296		29,296			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,000	9,000		9,000		9,000			32
33	Real Estate Taxes			296	296		296		296			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			46,488	46,488	(7,896)	38,592		38,592			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					11,778	11,778		11,778			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,527	67,527		67,527		67,527			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			67,527	67,527	11,778	79,305		79,305			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	656,846	111,846	448,910	1,217,602		1,217,602	23,700	1,241,302			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: 07/01/2016 Ending: 06/30/2017

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	(288)	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)**	$ (848)		$	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)	24,548	21,22	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,548		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 23,700		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.		X	$ 11,778		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)**			$ 11,778		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2016

Ending: 06/30/2017

	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	(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	(288)	0	0	0	0	0	0	0	0	0	0	(288)	20
21	Clerical & General Office Expenses	0	21,847	0	0	0	0	0	0	0	0	0	21,847	21
22	Employee Benefits & Payroll Taxes	0	2,701	0	0	0	0	0	0	0	0	0	2,701	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	(288)	24,548	0	0	0	0	0	0	0	0	0	24,260	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(848)	24,548	0	0	0	0	0	0	0	0	0	23,700	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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)**	(848)	24,548	0	0	0	0	0	0	0	0	0	23,700	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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)		21,847	21,847	6
7	V	22	Benefits		(see details, schedule VIII, Page 8		2,701	2,701	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 24,548	$ * 24,548	14

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	CONNIE DEMARANVILLE	0						3
4	BILL SULLIVAN	0						4
5	KYLE GIBSON	0						5
6	MEREDITH HAMMER	0						6
7	MARY ANN HILL	0						7
8	RICK TURNROTH	0						8
9	CONNIE VON HOLTON	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: 07/01/2016 Ending: 06/30/2017

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: 07/01/2016 Ending: 6/30/2017

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 Adminstrative 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	7,580,768	6.5	$ 216,357	$ 216,357	765,492	$ 21,847	1
2	22	FICA	SALARIES / BENEFITS	7,580,768	6.5	12,305		765,492	1,243	2
3	22	WORKERS COMP	SALARIES / BENEFITS	7,580,768	6.5	6,077		765,492	614	3
4	22	LIFE INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	1,105		765,492	112	4
5	22	HEALTH INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	2,600		765,492	263	5
6	22	VISION INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	174		765,492	18	6
7	22	DENTAL INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	709		765,492	72	7
8	22	ST & LT DISABILITY INS	SALARIES / BENEFITS	7,580,768	6.5	979		765,492	99	8
9	22	CHILD CARE	SALARIES / BENEFITS	7,580,768	6.5	2,770		765,492	280	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					$ 243,076	$ 216,357		$ 24,548	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	NO	7/26/16	200,000	200,000	7/30/17	3.9500	9,000	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 200,000			$ 9,000	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 200,000	$ 200,000			$ 9,000	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: 07/01/2016 Ending: 06/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 296	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.)		$ 296	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 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:			
	2012	320	8
	2013	321	9
	2014	291	10
	2015	301	11
	2016	301	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STRIVE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0036921

CONTACT PERSON REGARDING THIS REPORT Robin Landis

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 296.00	$ 296.00
2.		5MR 10236-94-26402X	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 296.00	$ 296.00

B. **Real Estate Tax Cost Allocations**

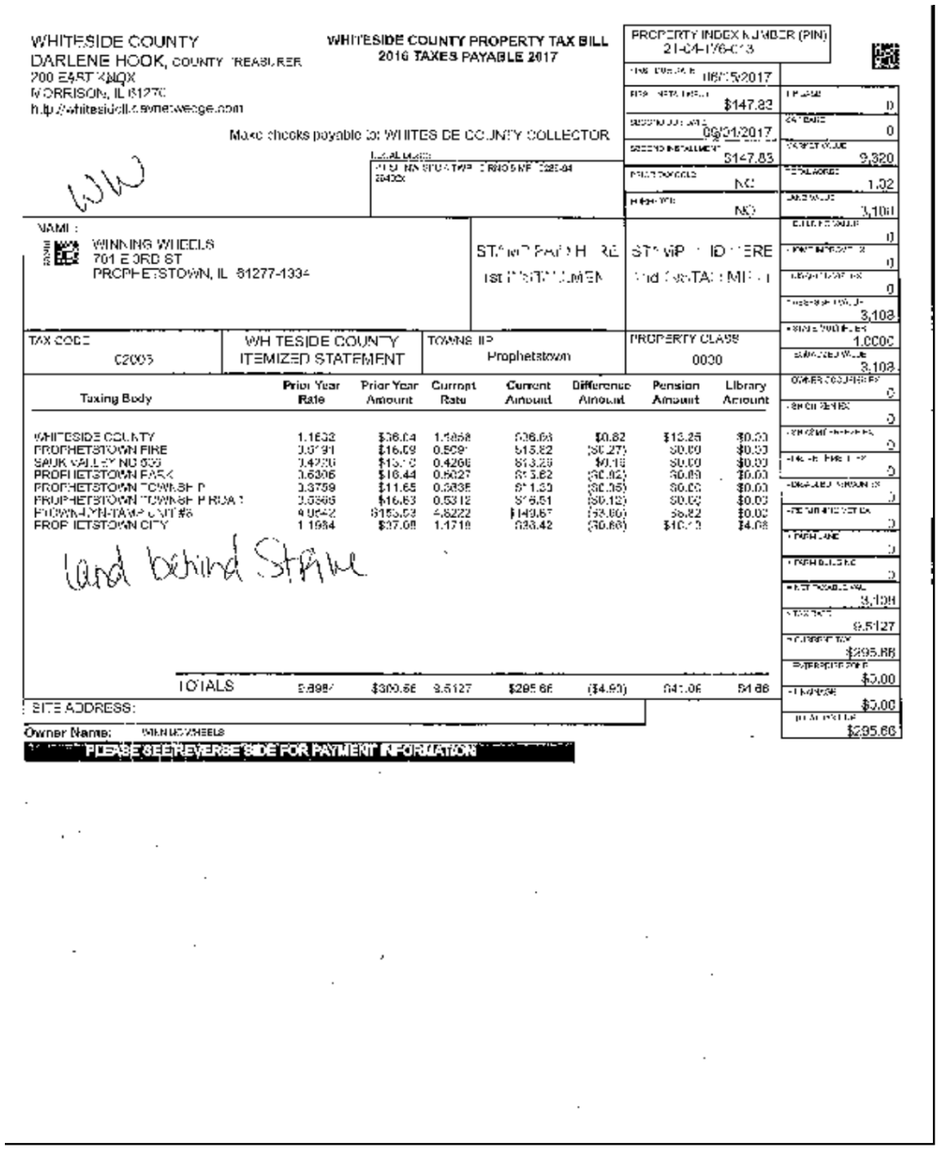
Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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
http://whitesidoil.gwnetwedge.com

WHITESIDE COUNTY PROPERTY TAX BILL
2016 TAXES PAYABLE 2017

Make checks payable to: WHITESIDE COUNTY COLLECTOR

WW

PROPERTY INDEX NUMBER (PIN)
21-04-176-013

FIRST INSTALLMENT	$147.83
SECOND INSTALLMENT	$147.83
PENALTY	0
COST	0
PROPERTY CODE	9,320
EQUALIZER	1.02
ASSESSOR	3,161
EXEMPTIONS	0
HOMESTEAD	0
SENIOR CITIZEN	0
TAXABLE VALUE	3,103
TAX RATE	1.0000
EQUALIZED VALUE	3,103
OWNER OCCUPIED	0
SENIOR FREEZE	0
DISABLED VETERAN	0
HOMESTEAD IMPROVEMENT	0
DISABLED PERSON	0
FARMLAND	0
FARM BUILDING	0
NET TAXABLE VAL	3,103
TAX RATE	9.5127
EXTENSION	$295.66
REFUNDED TAX	$0.00
TOTAL DUE	$295.66

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

STAMP PAID HERE
1st INSTALLMENT

STAMP PAID HERE
2nd INSTALLMENT

TAX CODE	ITEMIZED STATEMENT	TOWNSHIP	PROPERTY CLASS
02005	WHITESIDE COUNTY	Prophetstown	0030

Taxing Body	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Difference Amount	Pension Amount	Library Amount
WHITESIDE COUNTY	1.1632	$36.04	1.1858	$36.86	$0.82	$13.25	$0.00
PROPHETSTOWN FIRE	3.9791	$16.09	0.5091	$15.82	($0.27)	$0.00	$0.00
SAUK VALLEY NO 509	0.4278	$13.28	0.4266	$13.23	($0.05)	$0.00	$0.00
PROPHETSTOWN PARK	3.6306	$18.44	0.5627	$17.62	($0.82)	$0.00	$0.00
PROPHETSTOWN TOWNSHIP	0.3759	$11.65	0.3636	$11.33	($0.32)	$0.00	$0.00
PROPHETSTOWN TOWNSHIP ROAD	0.5366	$16.63	0.5112	$15.51	($0.12)	$0.00	$0.00
PROWN-LYNN-TAMP CONT #6	4.0542	$155.53	4.8222	$149.67	($5.86)	$6.82	$0.00
PROPHETSTOWN CITY	1.1984	$37.08	1.1719	$36.42	($0.66)	$10.19	$4.08

land behind Stone

TOTALS	9.8997	$309.66	9.5127	$295.66	($4.93)	$41.06	$4.08

SITE ADDRESS:

Owner Name: WINNINGWHEELS

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 APRATMENTS, 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: 07/01/2016 Ending: 06/30/2017

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	$ 9,441	40	$ 9,441	$	$ 247,434	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1992	7,906	155	34	155		5,681	9
10	REMODELING			1993	2,920		20			2,920	10
11	REMODELING			1995	2,556		14			2,556	11
12	REMODELING			1996	1,805	3	15	3		1,805	12
13	REMODELING			1997	43,489	1,527	15	1,527		36,062	13
14	REMODELING			1998	5,075	166	12.5	166		4,992	14
15	REMODELING			1999	5,386		10			5,386	15
16	REMODELING			2000	6,085	56	15	56		5,913	16
17	REMODELING			2001	42,569	1,121	21.89	1,121		30,524	17
18	REMODELING			2002	96,262	3,150	13	3,150		71,514	18
19	REMODELING			2005	4,270	285	15	285		3,440	19
20	REMODELING			2006	177,391	5,767	18.5	5,767		65,422	20
21	REMODELING			2008	928		7			928	21
22	REMODELING			2009	16,840	1,207	7.33	1,207		14,348	22
23	REPLACE WALL CAPET THROUGHOUT BUILDING			2010	5,208	372	7	372		5,208	23
24	ROOF ON MAIN BUILDING			2010	16,654	1,110	15	1,110		7,772	24
25	PAINTING MAIN HALLWAY AND DINING ROOM			2011	3,196	457	7	457		2,968	25
26	FLOORING AND WALL CARPET IN MAIN HALLWAYS			2012	5,212	521	5	521		5,212	26
27	CARPET IN FOUR RESIDENT ROOMS			2012	4,101	586	7	586		3,222	27
28	WIRING FOR GENERATOR PREPARATION			2014	10,750	538	7	538		1,702	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 26,462		$ 26,462	$	$ 525,009	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: 07/01/2016 Ending: 06/30/2017

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	$ 49,002	$ 6,409	$ 6,409	$	7.65	$ 35,795	71
72	Current Year Purchases	754	251	251		3	251	72
73	Fully Depreciated Assets	205,237				8.75	205,237	73
74								74
75	TOTALS	$ 254,993	$ 6,660	$ 6,660	$		$ 241,283	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	$ 4,070	$ 4,070	$	7	$ 56,975	76
77	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	53,867				5	53,867	77
78										78
79										79
80	TOTALS			$ 110,842	$ 4,070	$ 4,070	$		$ 110,842	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,271,064	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,192	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,192	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)	$ 877,134	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: 07/01/2016 Ending: 06/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 07/01/2016 Ending: 06/30/2017

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		363	817		363	817	4
5	Physician Care		visits							5
6	Dental Care	15.3	visits		40	2,925		40	2,925	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10.3	# of prescrpts		17	828		17	828	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICARE THERAP	10a.3			1,203	2,706		1,203	2,706	12
13	Other (specify): PHYSIATRIAN	9.3			12	2,600		12	2,600	13
14	TOTAL			$	1,635	$ 9,876	$	1,635	$ 9,876	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:** 07/01/2016 **Ending:** 06/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2017 (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	$ 5,156	$ 97,151	1
2	Cash-Patient Deposits	4,443	41,933	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	103,301	973,485	3
4	Supply Inventory (priced at COST)	9,516	37,043	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,150	25,401	6
7	Other Prepaid Expenses	10,099	97,724	7
8	Accounts Receivable (owners or related parties)		1,308,718	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 133,665	$ 2,581,455	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	359,861	13
14	Buildings, at Historical Cost	836,278	15,121,862	14
15	Leasehold Improvements, at Historical Cost	365,865	4,353,621	15
16	Equipment, at Historical Cost	(877,134)	(10,334,417)	16
17	Accumulated Depreciation (book methods)	10,949	33,115	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		558,309	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		266	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 404,909	$ 10,092,617	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 538,574	$ 12,674,072	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,443	$ 989,876	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,443	49,737	28
29	Short-Term Notes Payable	200,000	1,949,897	29
30	Accrued Salaries Payable	11,164	220,661	30
31	Accrued Taxes Payable (excluding real estate taxes)		80,832	31
32	Accrued Real Estate Taxes(Sch.IX-B)	296	17,450	32
33	Accrued Interest Payable		13,262	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKERS COMP		14,088	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 337,346	$ 3,335,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,598,401	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)**	$	$ 5,647,430	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 337,346	$ 8,983,233	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 201,228	$ 3,690,839	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 538,574	$ 12,674,072	48

***(See instructions.)**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,176,153	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,176,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,466)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) RELATED ENTITIES	(395,848)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (485,314)	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)**	$ 3,690,839	24 *

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 1,108,406	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,107,206	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,372	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,372	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,780	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,780	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	11,778	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,778	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,128,136	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	252,631	31
32	Health Care	535,352	32
33	General Administration	315,604	33
	B. Capital Expense		
34	Ownership	46,488	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	67,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,217,602	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,466)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,466)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,108,406	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)	$ 1,108,406	49

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

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

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

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	1,902	2,126	37,969	17.86	9
10	Activity Assistants	1,665	1,997	20,831	10.43	10
11	Social Service Workers	1,944	2,255	45,501	20.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,824	2,217	32,595	14.70	14
15	Cook Helpers/Assistants	3,991	4,220	35,861	8.50	15
16	Dishwashers					16
17	Maintenance Workers	2,014	2,222	40,233	18.11	17
18	Housekeepers	3,191	3,027	31,728	10.48	18
19	Laundry	420	420	3,580	8.52	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,856	2,085	40,083	19.22	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)	26,005	29,107	368,465	12.66	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	44,812	49,676	$ 656,846 *	$ 13.22	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	$ 1,236	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	828	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	40	2,925	15.3	46
47	PHYSIATRIAN	12	2,600	9.3	47
48					48
49	TOTAL (lines 35 - 48)	99	$ 7,589		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 1,660	10.3	50
51	Licensed Practical Nurses	515	14,525	10.3	51
52	Certified Nurse Assistants/Aides	207	2,547	10.3	52
53	TOTAL (lines 50 - 52)	738	$ 18,732		53

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMIN	0	$ 80,366
(INCLUDED IN AERICAN HEALTH			(80,366)
ENTERPRISES IN B BELOW)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
AMERICAN HEALTH ENTERPRISES	128,331
TOTAL (agree to Schedule V, line 17, col. 3)	$ 128,331
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RELIAS	TTRAINING SOFTWARE	$ 1,452
JOHN PYSE CONSULT	IT CONSULTANT	5,202
MARCUM	AUDIT FIRM	11,000
MIDWEST AUTO TIME	TIMECLOCK SOFTWARE	1,043
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 18,697

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,417
Unemployment Compensation Insurance	
FICA Taxes	50,749
Employee Health Insurance	14,922
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	2,728
DISABILITY INSURANCE	8,363
CHILD CARE	1,080
PROF LICENSE AND TRAINING	305
DENTAL / VISION INSURANCE	2,979
OTHER	80
5 YEAR BANQ / XMAS GIFT	4,725
TOTAL (agree to Schedule V, line 22, col.8)	$ 111,348

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	275
Health Care Worker Background Check	
(Indicate # of checks performed 2)	100
Patient Background Checks	
COMMUNITY RELATIONS	76
IHCA DUES	960
Less: Public Relations Expense	(288)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,123

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	384
Seminar Expense	959
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,343

**See instructions.

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,918** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **67,527**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NONE** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **11,778**
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 LLP**

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

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

STRIVE 36921
Report Period Beginning 7/1/16
Report Period Ending 6/30/17
DETAIL SCHEDULE - V-LINE 24

			In State	Mileage
1	Name & Title	Toni Williar / Nancy Cummings		
	Date of Seminar	09/21/2016 - 09/23/2016		
	Location	Arlington Heights		
	Title of Seminar	2016 IAPA Conference		
	Sponsor	IAPA - Il Activity Professional Association		
	Cost	$783.74	$606.08	$177.66
2	Name & Title	Anne Dunbar, Administrator		
		Nancy Cummings, Day Treament Coordinator		
	Date of Seminar	1/27/2017		
	Location	Alsip, IL		
	Title of Seminar	Network for Good		
	Sponsor	The Arc of IL		
	Cost	$309.00	$309.00	
3	Name & Title	Anne Dunbar / Ethan Gapinski		
	Date of Seminar	6/15/201706/15/2017		
	Location	Springfield IL		
	Title of Seminar	DD Symposium		
	Sponsor	IHCA		
	Cost	$250.00	$250.00	
			$1,165.08	$177.66

Total Seminars	$1,342.74
Less: Out of State Travel & Seminars	$0.00
Total Travel and Seminars	$1,342.74
Total - Schedule V, Line 24 - Other	$1,342.74
Total - Schedule V, Line 24 - Adjustments	$0.00