

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0036921

Facility Name: STRIVE

Address: 415 A STREET PROPHESTOWN 61277
Number City 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:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(C)3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 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) 11/06/2012
(Date)

(Type or Print Name) MILT RUE

(Title) CFO

Paid
Preparer

(Signed)
(Date)

(Print Name
and Title)

(Firm Name
& Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number STRIVE# 0036921 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,739			5,739	13
14	TOTALS	5,739			5,739	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.00%

D. How many bed-hold days during this year were paid by the Department?

113 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

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 ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	68,645	5,572	720	74,937		74,937		74,937		1
2	Food Purchase		47,902		47,902		47,902		47,902		2
3	Housekeeping	18,665	4,232		22,897		22,897		22,897		3
4	Laundry	4,890	3,340		8,230		8,230		8,230		4
5	Heat and Other Utilities			16,788	16,788		16,788	(1,307)	15,481		5
6	Maintenance	37,137	14,890	13,040	65,067		65,067		65,067		6
7	Other (specify):*										7
8	TOTAL General Services	129,337	75,936	30,548	235,821		235,821	(1,307)	234,514		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	361,155	34,752	23,740	419,647		419,647	1,752	421,399		10
10a	Therapy										10a
11	Activities	44,909	3,859		48,768		48,768		48,768		11
12	Social Services	41,263			41,263		41,263		41,263		12
13	CNA Training										13
14	Program Transportation		4,327		4,327	3,587	7,914		7,914		14
15	Other (specify):* DENTAL SERVICES			2,340	2,340		2,340		2,340		15
16	TOTAL Health Care and Programs	447,327	42,938	29,080	519,345	3,587	522,932	1,752	524,684		16
	C. General Administration										
17	Administrative			125,613	125,613		125,613		125,613		17
18	Directors Fees										18
19	Professional Services			17,772	17,772		17,772		17,772		19
20	Dues, Fees, Subscriptions & Promotions			3,113	3,113		3,113	(45)	3,068		20
21	Clerical & General Office Expenses	36,526	6,535	4,559	47,620		47,620	20,390	68,010		21
22	Employee Benefits & Payroll Taxes			101,513	101,513		101,513	3,077	104,590		22
23	Inservice Training & Education			270	270		270		270		23
24	Travel and Seminar			8,532	8,532	(3,587)	4,945		4,945		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,679	3,679		3,679		3,679		26
27	Other (specify):*										27
28	TOTAL General Administration	36,526	6,535	265,051	308,112	(3,587)	304,525	23,422	327,947		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	613,190	125,409	324,679	1,063,278		1,063,278	23,867	1,087,145		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			47,568	47,568		47,568	(1,626)	45,942			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			339	339		339		339			32
33	Real Estate Taxes			316	316		316		316			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			48,223	48,223		48,223	(1,626)	46,597			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,432	61,432		61,432		61,432			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			61,432	61,432		61,432		61,432			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	613,190	125,409	434,334	1,172,933		1,172,933	22,241	1,195,174			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Page 3, Schedule V

Line #		DR.	CR.
	<u>RECLASSIFICATIONS</u>		
14	Transportation	\$ 3,587	
24	Travel and Seminar		\$ 3,587
	Travel and Seminar for Nursing Staff		

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,307)	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	(45)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	126			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,226)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,467	21, 22	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 23,467		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 22,241		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STRIVE

Report Period Beginning: ID# 0036921

Ending: 07/01/2011

06/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	DEPRECIATION ON ITEMS UNDER \$2,500	\$ (1,626)	30	1
2	NEW EQUIPMENT UNDER \$2,500	1,752	10	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	126		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	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	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	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	1,752	0	0	0	0	0	0	0	0	0	0	1,752	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	1,752	0	0	0	0	0	0	0	0	0	0	1,752	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	(45)	0	0	0	0	0	0	0	0	0	0	(45)	20
21	Clerical & General Office Expenses	0	20,390	0	0	0	0	0	0	0	0	0	20,390	21
22	Employee Benefits & Payroll Taxes	0	3,077	0	0	0	0	0	0	0	0	0	3,077	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	(45)	23,467	0	0	0	0	0	0	0	0	0	23,422	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	400	23,467	0	0	0	0	0	0	0	0	0	23,867	29

Summary B

06/30/2012

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC	100%	WINNING WHEELS	PROPHETSTOWN	LYNDON PROGRESS CENTER	LYNDON	DAY TREATMENT REHABILITATION
				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	22	CHILDCARE BENEFITS	\$ 5,872	LYNDON PLAY AND LEARN CENTER		\$ 6,288	\$ 416	1
2	V								2
3	V								3
4	V		ADMINISTRATIVE OVERHEAD						4
5	V	21	CLERICAL SALARIES		WINNING WHEELS, INC (ADMINISTRATIVE FUND)		20,390	20,390	5
6	V	22	BENEFITS		(SEE DETAILS, SCHEDULE VIII, PAGE 8)		2,661	2,661	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 5,872			\$ 29,339	\$ * 23,467	14

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

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	BOD						2
3	DAVID MICKLEY - VICE PRESIDENT	BOD						3
4	KYLE GIBSON - TREASURER	BOD						4
5	MARY ANN HILL - SECRETARY	BOD						5
6	MEREDITH HAMMER	BOD						6
7	CONNIE DEMARANVILLE	BOD						7
8	BILL SULLIVAN	BOD						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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	6,198,278	7	\$ 176,221	\$ 176,221	717,198	\$ 20,390	1
2	22	FICA	SALARIES/BENEFITS	6,198,278	7	10,240		717,198	1,185	2
3	22	WORKMAN'S COMP	SALARIES/BENEFITS	6,198,278	7	379		717,198	44	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	6,198,278	7	430		717,198	50	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	6,198,278	7	3,938		717,198	456	5
6	22	403 B RETIREMENT	SALARIES/BENEFITS	6,198,278	7	1,763		717,198	204	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	6,198,278	7	360		717,198	42	7
8	22	ST & LT DISABILITY INSURAN	SALARIES/BENEFITS	6,198,278	7	1,643		717,198	190	8
9	22	CHILD CARE	SALARIES/BENEFITS	6,198,278	7	3,711		717,198	429	9
10	22	OTHER	SALARIES/BENEFITS	6,198,278	7	527		717,198	61	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					\$ 199,212	\$ 176,221		\$ 23,051	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	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		10/8/11	200,000	160,000	1/1/13	2.5400	339		6	
7													7	
8													8	
9	TOTAL Facility Related						\$ 200,000	\$ 160,000			\$ 339		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	\$ 160,000			\$ 339		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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	308	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	316	2
3. Under or (over) accrual (line 2 minus line 1).			\$	8	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	308	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	316	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	282	8		
	2008	304	9		
	2009	308	10		
	2010	311	11		
	2011	316	12		

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
STRIVE

COUNTY
WHITESIDE

FACILITY IDPH LICENSE NUMBER
0036921

CONTACT PERSON REGARDING THIS REPORT
MILT RUE

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

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	21-04-176-013	PT SE NW SEC 4 TWP 19 RNG	\$ 316.38	\$ 316.38
2.		5 MR 10236-94 26402x	\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 316.38	\$ 316.38

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

WHITESIDE COUNTY PROPERTY TAX BILL
2011 TAXES PAYABLE 2012

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



Make checks payable to: WHITESIDE COUNTY COLLECTOR

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

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

STAMP PAID HERE
1st INSTALLMENT

STAMP PAID HERE
2nd INSTALLMENT

TAX CODE
02005

WHITESIDE COUNTY
ITEMIZED STATEMENT

TOWNSHIP
Prophetstown

PROPERTY CLASS
1023

Taxing Body	Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	Difference Amount	Pension Amount	Library Amount
WHITESIDE COUNTY	1.1141	\$38.25	1.0863	\$38.18	(\$0.07)	\$12.07	\$0.00
PROPHETSTOWN FIRE	0.4203	\$14.43	0.4217	\$14.82	\$0.39	\$0.00	\$0.00
SAUK VALLEY NO 506	0.4433	\$15.22	0.4422	\$15.54	\$0.32	\$0.00	\$0.00
PROPHETSTOWN PARK	0.4204	\$14.43	0.4079	\$14.34	(\$0.09)	\$0.90	\$0.00
PROPHETSTOWN TOWNSHIP	0.3681	\$12.64	0.3582	\$12.59	(\$0.05)	\$0.00	\$0.00
PROPHETSTOWN TOWNSHIP ROAD	0.5361	\$18.40	0.5356	\$18.83	\$0.43	\$0.00	\$0.00
PTOWN-LYN-TAMP UNIT #3	4.7643	\$163.56	4.7662	\$167.53	\$3.97	\$13.28	\$0.00
PROPHETSTOWN CITY	0.9842	\$33.79	0.9828	\$34.55	\$0.76	\$16.66	\$3.75

RECEIVED MAY 11

TOTAL 9.0508 \$310.72 9.0009 \$316.38 \$5.66 \$42.91 \$3.75

SITE ADDRESS:

Owner Name: WINNING WHEELS

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

FIRST DUE DATE 06/08/2012	TIF BASE 0
FIRST INSTALLMENT \$158.19	SAF BASE 0
SECOND DUE DATE 09/07/2012	MARKET VALUE 10,545
SECOND INSTALLMENT \$158.19	TOTAL ACRES 1.02
PRIOR TAX SOLD NO	LAND VALUE 3,515
FORFEITED NO	+ BUILDING VALUE 0
	- HOME IMPROVEMENT EX 0
	- DISABLED VET EX 0
	= ASSESSED VALUE 3,515
	x STATE MULTIPLIER 1.0000
	= EQUALIZED VALUE 3,515
	- OWNER OCCUPIED EX 0
	- SR CITIZEN EX 0
	- SR ASMT FREEZE EX 0
	- DISABLED VET HMSTD EX 0
	- DISABLED PERSON EX 0
	- RETURNING VET EX 0
	+ FARM LAND 0
	+ FARM BUILDING 0
	= NET TAXABLE VAL. 3,515
	x TAX RATE 9.0009
	= CURRENT TAX \$316.38
	- ENTERPRISE ZONE \$0.00
	+ DRAINAGE \$0.00
	= TOTAL TAX DUE \$316.38

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? ☒ (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? ☒ (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 ☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1991</u>	<u>\$ 10,207</u>	1
2			<u>1995-2007</u>	<u>58,744</u>	2
3	TOTALS			<u>\$ 68,951</u>	3

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	\$	\$ 200,225	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1992	7,906	155	34	155		4,904	9
10	REMODELING			1993	2,920	146	20	146		2,786	10
11	REMODELING			1995	2,556	183	14	183		1,917	11
12	REMODELING			1996	1,805	9	15	9		1,766	12
13	REMODELING			1997	43,489	1,527	15	1,527		28,427	13
14	REMODELING			1998	5,075	166	13	166		4,162	14
15	REMODELING			1999	5,386		10			5,386	15
16	REMODELING			2000	6,085	56	15	56		5,635	16
17	REMODELING			2001	42,569	1,558	22	1,558		24,919	17
18	REMODELING			2002	96,262	3,150	13	3,150		55,764	18
19	REMODELING			2005	4,270	285	15	285		2,016	19
20	REMODELING			2006	177,391	6,394	19	6,394		35,648	20
21	CARPET			2008	928	133	7	133		596	21
22	TILE MAIN ENTRY			2009	3,930	786	5	786		2,751	22
23	PATCH WORK IN PARKING LOT			2009	2,940	420	7	420		1,050	23
24	PAVILLION - OUTDOOR COVERED PATIO			2009	9,970	997	10	997		2,493	24
25	REPLACE WALL CARPET			2010	5,208	744	7	744		1,860	25
26	ROOF ON MAIN BUILDING			2010	16,654	1,110	15	1,110		2,221	26
27	PAINTING			2011	3,196	457	7	457		685	27
28	FLOORING			2011	1,242	177	7	177		266	28
29	FLOORING AND WALL CARPET			2012	5,212	521	5	521		521	29
30	BEDROOM CARPETING			2012	4,101	293	7	293		293	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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)		\$ 826,770	\$ 28,709		\$ 28,709	\$	\$ 386,291	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$62,094	\$7,686	\$7,686	\$	7.8	\$46,751	71
72	Current Year Purchases	14,081	1,408	1,408		5	1,408	72
73	Fully Depreciated Assets	139,495				8.6	139,495	73
74								74
75	TOTALS	\$215,670	\$9,094	\$9,094	\$		\$187,654	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	2005 FORD SHUTTLE BUS	2005	\$53,867	\$	\$	\$	5	\$53,867	76
77	RESIDENT OUTINGS	2009 FORD SHUTTLE BUS	2009	56,975	8,139	8,139		7	20,348	77
78										78
79										79
80	TOTALS			\$110,842	\$8,139	\$8,139	\$		\$74,215	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)	\$1,222,233	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$45,942	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$45,942	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)	\$648,160	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	DESIGN WORK	\$21,591	92
93			93
94			94
95		\$21,591	95

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

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

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:
- *

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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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.)

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,866	\$ 199,004	1
2	Cash-Patient Deposits	2,675	22,861	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0 / 67,614)	366,950	1,715,941	3
4	Supply Inventory (priced at COST)	10,125	41,258	4
5	Short-Term Investments		30	5
6	Prepaid Insurance		17,664	6
7	Other Prepaid Expenses		16,081	7
8	Accounts Receivable (owners or related parties)		1,138,213	8
9	Other(specify): PG17_Support		434,219	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 382,616	\$ 3,585,271	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	231,451	13
14	Buildings, at Historical Cost	767,028	7,529,747	14
15	Leasehold Improvements, at Historical Cost	52,673	52,673	15
16	Equipment, at Historical Cost	333,284	2,397,503	16
17	Accumulated Depreciation (book methods)	(651,601)	(5,765,867)	17
18	Deferred Charges	10,949	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,771,235	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR. IN PROGRESS	21,591	280,590	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 602,875	\$ 6,530,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 985,491	\$ 10,115,718	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 345,261	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,675	22,861	28
29	Short-Term Notes Payable	160,000	1,499,204	29
30	Accrued Salaries Payable		208,057	30
31	Accrued Taxes Payable (excluding real estate taxes)		104,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)	316	316	32
33	Accrued Interest Payable		104	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE		12,536	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 162,991	\$ 2,192,975	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,459,956	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE		7,691	43
44	RESERVE FUND		4,742	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,472,389	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 162,991	\$ 3,665,364	46
47	TOTAL EQUITY(page 18, line 24)	\$ 822,500	\$ 6,450,354	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 985,491	\$ 10,115,718	48

*(See instructions.)

STRIVE
415 A STREET
PROPHETSTOWN, IL 61277
IDPH #0036921

FYE 2012

BALANCE SHEET PAGE 17

Line #

9	OTHER CURRENT ASSETS	
	Depoit in Frontier Hollow	\$ 392,662
	Deposit in Pinnacle Place	\$ 97,601
	Investment in Al's Place Limited Partnership	<u>\$ (56,044)</u>
	Total	<u><u>\$ 434,219</u></u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,170,967	1
2	Restatements (describe):		2
3	RECONCILE TO AUDIT	(333,905)	3
4	WRITE OFF DUE FROM SUBSIDIARY	(1,439,013)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,398,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(43,091)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) SUBSIDIARY COMPANIES	95,396	15
16	Other (describe) NET INCOME (LOSS)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 52,305	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)	\$ 6,450,354	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1	2	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,118,166	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,116,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	12,876	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,876	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,129,842	30

	1	2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	235,821	31
32	Health Care	519,345	32
33	General Administration	308,112	33
	B. Capital Expense		
34	Ownership	48,223	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	61,432	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,172,933	40
41	Income before Income Taxes (line 30 minus line 40)**	(43,091)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (43,091)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,116,966	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)	\$ 1,116,966	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? n/a If not, please attach a reconciliation.

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,772	1,910	30,175	15.80	9
10	Activity Assistants	1,005	1,205	14,734	12.23	10
11	Social Service Workers	1,986	2,138	41,263	19.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,116	2,310	29,597	12.81	14
15	Cook Helpers/Assistants	3,719	3,933	39,048	9.93	15
16	Dishwashers					16
17	Maintenance Workers	2,184	2,416	37,137	15.37	17
18	Housekeepers	1,919	2,062	18,665	9.05	18
19	Laundry	564	568	4,890	8.61	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,955	2,139	36,526	17.08	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)	27,162	30,026	361,155	12.03	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	44,382	48,707	\$ 613,190 *	\$ 12.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	18	\$ 720	1.3	35
36	Medical Director	24	3,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	496	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	29	2,340	15.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	77	\$ 6,556		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	601	16,048	10.3	51
52	Certified Nurse Assistants/Aides	302	4,673	10.3	52
53	TOTAL (lines 50 - 52)	903	\$ 20,721		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
ANNE DUNBAR	ADMINISTRATOR	0%	\$ 77,646
(Included in AMERICAN HEALTH ENTERPRISES Fee in B below)			(77,646)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$
B. Administrative - Other			
Description			Amount
AMERICAN HEALTH ENTERPRISES			\$ 125,613
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 125,613
C. Professional Services			
Vendor/Payee	Type		Amount
JOHN PYSE CONSULTING	COMPUTER CONSULTIN		\$ 2,731
WIPFLI, LLC	ANNUAL AUDIT FEES		11,535
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE		600
MARTIN, HOOD, FRIESE, & ASSC	403(b) AUDIT FEES		1,800
SILVERCHAIR	SOFTWARE FEES		566
MDI ACHIEVE	SOFTWARE FEES		540
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 17,772
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 14,228
Unemployment Compensation Insurance			
FICA Taxes			46,716
Employee Health Insurance			17,097
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
LIFE INSURANCE			1,402
RETIREMENT			5,418
DENTAL SERVICES			1,552
DISABILITY			6,026
CHILDCARE			6,717
PHYSICALS			1,704
OTHER BENEFITS			3,730
TOTAL (agree to Schedule V, line 22, col.8)			\$ 104,590
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			558
Health Care Worker Background Check (Indicate # of checks performed 1)			30
Patient Background Checks			
CARF			1,407
IHCA			839
NEWSPAPERS			234
COMMUNITY RELATIONS			45
Less: Public Relations Expense			(45)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 3,068
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			4,520
Seminar Expense			425
Entertainment Expense	(		)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 4,945

*** Attach copy of IMRF notifications**

****See instructions.**

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

		Total Cost	Nursing	General & Admin
1 Names & Titles	Anne Dunbar, Administrator Nancy Cummings, Director of Day Treatment			
Dates of Seminar	January 24, 2012			
Location	Alsip, IL			
Title of Seminar	QSP Conference			
Sponsor	The Arc			
Cost		\$ 300		\$ 300
2 Name & Title	Anne Dunbar, Administrator			
Dates of Seminar	June 6, 2012			
Location	Springfield, IL			
Title	DD Symposium			
Sponsor	IHCA			
Cost		\$ 125		\$ 125
	Total Seminars	\$ 425	\$ -	\$ 425
	Employee mileage reimbursement	\$ 8,107	\$ 3,587	\$ 4,520
	Less: Out of State Travel and Seminars	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>
Total - Schedule V, Line 14			\$ 3,587	
Total - Schedule V, Line 24		\$ 8,532		\$ 4,945

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

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

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

IL HEALTH CARE ASSOC. - \$839
- (3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES
- (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?

5.67
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

633

Line

10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

61,432

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

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

YES
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

NONE

Has any meal income been offset against related costs?

NO

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

YES

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

12,876

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?

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

CLIFTON LARSON ALLEN
- (18)

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

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

General Ledger Trial Balance for Period Ending 6/30/2012
STRIVE

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
5360-30	30	DIETARY	3	1.1	68,644.75		68,644.75
7360-30	30	DIETARY	3	1.2	5,571.69		5,571.69
7410-30	30	LEASES NON CLINICAL	3	1.2	-		-
6360-30	30	DIETARY	3	1.3	720.00		720.00
7370-30	30	FOOD	3	2.2	47,901.94		47,901.94
7375-30	30	SUPPLEMENTALS	3	2.2	-		-
5380-30	30	HOUSEKEEPING	3	3.1	18,665.22		18,665.22
7380-30	30	HOUSEKEEPING	3	3.2	4,231.56		4,231.56
5390-30	30	LAUNDRY	3	4.1	4,889.69		4,889.69
7390-30	30	LAUNDRY	3	4.2	3,340.19		3,340.19
6390-30	30	LAUNDRY	3	4.3	-		-
8010-30	30	ELECTRIC	3	5.3	8,606.01		8,606.01
8020-30	30	GAS	3	5.3	3,755.76		3,755.76
8040-30	30	WATER	3	5.3	1,925.75		1,925.75
8060-30	30	TRASH REMOVAL	3	5.3	866.06		866.06
8080-30	30	CABLEVISION	3	5.3	1,634.29		1,634.29
5420-30	30	MAINTENANCE	3	6.1	37,137.47		37,137.47
7420-30	30	MAINTENANCE	3	6.2	14,889.95		14,889.95
8100-30	30	REPAIRS & MAINTENANCE	3	6.3	13,039.76		13,039.76
6030-30	30	PHYSICIAN	3	9.3	3,000.00		3,000.00
5070-30	30	AIDES	3	10.1	361,155.46		361,155.46
7060-30	30	NURSING	3	10.2	25,468.89		25,468.89
7065-30	30	BRIEFS	3	10.2	193.37		193.37
7070-30	30	OXYGEN	3	10.2	-		-
7080-30	30	MATTRESSES / CUSHION:STR	3	10.2	-		-
7150-30	30	NURSE AIDE TRAINING:STR	3	10.2	-		-
7200-30	30	PHARMACY	3	10.2	8,954.54		8,954.54
7210-30	30	O.T.C MEDS	3	10.2	135.68		135.68
5720-30	30	UNIFORMS	3	10.3	2,522.21		2,522.21
6060-30	30	NURSES/AIDES	3	10.3	20,721.28		20,721.28
6150-30	30	PSYCHOLOGICAL	3	10.3	-		-
6200-30	30	PHARMACY	3	10.3	496.25		496.25
6220-30	30	LAB	3	10.3	-		-
5120-30	30	THERAPEUTIC SERVICES	3	11.1	44,908.69		44,908.69

General Ledger Trial Balance for Period Ending 6/30/2012
STRIVE

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
7120-30	30	RECREATION	3	11.2	3,858.90		3,858.90
6120-30	30	RECREATIONAL THERAPY	3	11.3	-		-
5140-30	30	SOCIAL SERVICES	3	12.1	41,263.35		41,263.35
7440-30	30	TRANSPORTATION	3	14.2	4,326.86		4,326.86
6040-30	30	DENTAL SERVICES	3	15.3	2,340.00		2,340.00
6460-30	30	ADMINISTRATIVE	3	17.3	125,613.00		125,613.00
6470-30	30	DATA PROCESSING	3	19.3	4,437.12		4,437.12
9100-30	30	LEGAL & ACCOUNTING	3	19.3	13,335.00		13,335.00
9020-30	30	DUES & SUBSCRIPTIONS	3	20.3	2,479.72		2,479.72
9110-30	30	MARKETING	3	20.3	-		-
9120-30	30	RECRUITMENT	3	20.3	558.59		558.59
9130-30	30	ADVERTISING	3	20.3	-		-
9170-30	30	BACKGROUND CHECK:STR	3	20.3	30.00		30.00
9190-30	30	COMMUNITY RELATIONS	3	20.3	45.00		45.00
9200-30	30	DONATIONS	3	20.3	-		-
5460-30	30	ADMINISTRATION	3	21.1	36,525.52		36,525.52
7460-30	30	OFFICE	3	21.2	6,450.36		6,450.36
7470-30	30	COMPUTER SUPPLIES	3	21.2	84.20		84.20
7480-30	30	OTHER	3	21.2	-		-
8090-30	30	INTERNET	3	21.3	1,712.36		1,712.36
9010-30	30	PHONE	3	21.3	2,189.68		2,189.68
9060-30	30	PRINTING	3	21.3	-		-
9080-30	30	POSTAGE	3	21.3	656.57		656.57
9160-30	30	LICENSE & TAXES	3	21.3	-		-
9180-30	30	OTHER	3	21.3	-		-
5620-30	30	FICA	3	22.3	45,531.49		45,531.49
5640-30	30	WORKER'S COMP	3	22.3	14,184.28		14,184.28
5650-30	30	UNEMPLOYMENT	3	22.3	-		-
5660-30	30	LIFE INSURANCE	3	22.3	1,351.91		1,351.91
5670-30	30	HEALTH INSURANCE	3	22.3	16,640.52		16,640.52
5680-30	30	403 B RETIREMENT	3	22.3	5,214.13		5,214.13
5685-30	30	DENTAL INSURANCE	3	22.3	1,510.00		1,510.00
5690-30	30	ST & LT DISABILITY INS.	3	22.3	5,836.33		5,836.33
5700-30	30	PHYSICALS	3	22.3	1,703.95		1,703.95

General Ledger Trial Balance for Period Ending 6/30/2012
STRIVE

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
5730-30	30	CHILD CARE	3	22.3	5,871.78		5,871.78
5735-30	30	PROFESSIONAL LICENSE FEE	3	22.3	312.45		312.45
5736-30	30	PROFESSIONAL TRAINING	3	22.3	-		-
5740-30	30	TUITION ASSISTANCE	3	22.3	-		-
5745-30	30	TUITION REIMBURSEMEN	3	22.3	-		-
5750-30	30	OTHER	3	22.3	3,356.37		3,356.37
9151-30	30	NURSE AID TRAINING	3	23.3	151.55		151.55
9150-30	30	TRAINING	3	23.3	118.07		118.07
9140-30	30	TRAVEL & SEMINAR	3	24.3	425.00		425.00
9141-30	30	TRAVEL EXPENSES-NON SEMINAR	3	24.3	8,106.76		8,106.76
9040-30	30	INSURANCE	3	26.3	3,679.02		3,679.02
7140-30	30	PT & OT	3	10a.2	-		-
7145-30	30	SPEECH THERAPY SPLS	3	10a.2	-		-
6100-30	30	PHYSICAL THERAPY	3	10a.3	-		-
9450-30	30	DEPRECIATION	4	30.3	47,567.64		47,567.64
9460-30	30	AMORTIZATION:STR	4	30.3		-	-
9340-30	30	INTEREST EXPENSE - STRIVE	4	32.3	338.67		338.67
8130-30	30	REAL ESTATE TAXES	4	33.3	316.38		316.38
8120-30	30	RENT	4	34.3	-		-
4120-30	30	ASSESSMENT FEE TAX	4	42.3	61,431.95		61,431.95
					1,172,930.94	-	1,172,930.94
							1,172,933.00
							(2.06)
1100-30	30	PETTY CASH	17	1.1	250.00		250.00
1110-30	30	FARMERS NATIONAL BANK	17	1.1	2,616.38		2,616.38
1190-30	30	RESIDENT TRUST ACCOUNTS - STRIV	17	2.1	2,675.34		2,675.34
1210-02	30	PUBLIC AID - STRIVE	17	3.1	366,949.67		366,949.67
1350-30	30	INVENTORY	17	4.1	10,125.00		10,125.00
1720-30	30	LAND - STRIVE	17	13.1	68,951.37		68,951.37
1850-00	30	BUILDING - STRIVE	17	14.1	725,885.52		725,885.52
1852-00	30	SITE IMPROVEMENTS - STRIVE	17	14.1	41,142.83		41,142.83
1855-00	30	LEASEHOLD IMPROVEMENTS- STRIV	17	15.1	52,673.37		52,673.37
1800-00	30	VEHICLE - STRIVE	17	16.1	110,842.00		110,842.00

General Ledger Trial Balance for Period Ending 6/30/2012
STRIVE

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
1870-00	30	EQUIPMENT - STRIVE	17	16.1	222,442.22		222,442.22
1830-00	30	ACCUM. DEPR. - STRIVE VEHICLE	17	17.1		74,215.22	(74,215.22)
1860-00	30	ACCUM. DEPR. - BLDG. - STRIVE	17	17.1		334,854.57	(334,854.57)
1862-00	30	ACCUM. DEPR. - SITE IMPR.	17	17.1		18,876.64	(18,876.64)
1865-00	30	ACCUM. DEPR. - LSHLD. IMPR.	17	17.1		27,049.39	(27,049.39)
1880-00	30	ACCUM. DEPR. - EQUIPMENT	17	17.1		189,142.83	(189,142.83)
1945-00	30	ACCUM DEPR - DEF MNT COSTS-STR	17	17.1		7,461.99	(7,461.99)
1935-00	30	DEFERRED COSTS - STRIVE	17	18.1	10,948.83		10,948.83
1910-00	30	STRIVE CONSTR. IN PROGRESS	17	23.1	21,591.10		21,591.10
2371-30	30	VOLUNTARY LIFE:STR	17	26.1		-	-
2373-30	30	DENTAL:STR	17	26.1		-	-
2374-30	30	VISION:STR	17	26.1		-	-
2125-30	30	RESIDENT TRUST ACCOUNTS PAYAB	17	28.1		2,675.34	(2,675.34)
2060-30	30	LINE OF CREDIT - FNB	17	29.1		160,000.00	(160,000.00)
2145-00	30	ACCRUED REAL ESTATE TAXES	17	32.1		316.00	(316.00)
2070-00	30	MORTGAGE - STRIVE	17	40.1		-	-
2570-00	30	MORTGAGE - STRIVE	17	40.1		-	-
2960-30	30	FUND BALANCE	17	47.1		865,590.91	(865,590.91)
							985,492.99
							985,491.00
							1.99
3920-03	30	PUBLIC AID	19	1.1		-	-
3920-30	30	PUBLIC AID - STRIVE	19	1.1		5,852.00	(5,852.00)
3990-30	30	RESIDENT DAYS OFFSET TOTAL - ST	19	1.1	5,852.00		5,852.00
4020-30	30	PUBLIC AID	19	1.1		1,113,944.59	(1,113,944.59)
4150-30	30	BAD DEBTS	19	2.1	1,200.00		1,200.00
4370-30	30	HAB-AIDE TRAINING	19	1.1		3,003.00	(3,003.00)
4300-30	30	MEALS	19	14.1		-	-
4360-30	30	INTEREST	19	25.1		-	-
4385-30	30	GAIN (LOSS) ON SALE	19	25.1		-	-
4240-30	30	TRANSPORTATION	19	28.1		12,875.55	(12,875.55)
4375-30	30	EMPLOYEES AT OTHER FACILITIES	19	1.1		1,161.19	(1,161.19)
4380-30	30	MISCELLANEOUS	19	1.1		57.35	(57.35)

General Ledger Trial Balance for Period Ending 6/30/2012
STRIVE

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
							(1,129,841.68)
							1,129,842.00
							0.32
					2,817,076.57	2,817,076.57	(0.00)