FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0036921

Facility Name: STRIVE

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

County: WHITESIDE

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

HFS ID Number:

Date of Initial License for Current Owners: 4/9/1991

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROBIN 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 07/01/2024 to 6/30/2025 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) Britney Dickman
(Title) Administrator

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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	5,856	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	5,120							5,120	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,120							5,120	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 87.43%

D. How many bed reserve days during this year were paid by the Department?
0 (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 7/9/91

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 certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	43,544	4,709	1,388	49,641		49,641		49,641			1
2	Food Purchase		37,642		37,642		37,642		37,642			2
3	Housekeeping	36,917	6,114		43,031		43,031		43,031			3
4	Laundry		3,194		3,194		3,194		3,194			4
5	Heat and Other Utilities			31,976	31,976		31,976	(3,651)	28,325			5
6	Maintenance	12,403	11,385	6,314	30,102		30,102		30,102			6
7	Other (specify):*											7
8	**TOTAL General Services**	92,864	63,044	39,678	195,586		195,586	(3,651)	191,935			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	611,923	26,905	1,280	640,108		640,108		640,108			10
10a	Therapy											10a
11	Activities	67,414	4,802		72,216		72,216		72,216			11
12	Social Services	55,148			55,148		55,148		55,148			12
13	CNA Training											13
14	Program Transportation		3,979		3,979		3,979		3,979			14
15	Other (specify):* Psychological			1,350	1,350		1,350		1,350			15
16	**TOTAL Health Care and Programs**	734,485	35,686	3,830	774,001		774,001		774,001			16
	C. General Administration											
17	Administrative	21,535		98,144	119,679		119,679		119,679			17
18	Directors Fees											18
19	Professional Services			35,994	35,994		35,994		35,994			19
20	Dues, Fees, Subscriptions & Promotions			4,790	4,790		4,790	(415)	4,375			20
21	Clerical & General Office Expenses	53,835	9,507	3,976	67,318		67,318	26,929	94,247			21
22	Employee Benefits & Payroll Taxes			177,177	177,177		177,177	4,335	181,512			22
23	Inservice Training & Education			4,076	4,076		4,076		4,076			23
24	Travel and Seminar			809	809		809		809			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,178	72,178		72,178		72,178			26
27	Other (specify):*											27
28	**TOTAL General Administration**	75,370	9,507	397,144	482,021		482,021	30,849	512,870			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	902,719	108,237	440,652	1,451,608		1,451,608	27,198	1,478,806			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: 07/01/2024 Ending: 6/30/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,570	45,570		45,570	(996)	44,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			45,570	45,570		45,570	(996)	44,574			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			97,856	97,856		97,856		97,856			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			97,856	97,856		97,856		97,856			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	902,719	108,237	584,078	1,595,034		1,595,034	26,202	1,621,236			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: 07/01/2024 Ending: 6/30/2025

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	(3,651)	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	(996)	30		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	(415)	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)**	$ (5,062)		$	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)	31,264		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31,264		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 26,202		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/2024

Ending: 6/30/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (415)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	CABLE	(3,651)	5	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**	(4,066)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,651)	0	0	0	0	0	0	0	0	0	0	(3,651)	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**	(3,651)	0	0	0	0	0	0	0	0	0	0	(3,651)	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	(415)	0	0	0	0	0	0	0	0	0	0	(415)	20
21	Clerical & General Office Expenses	0	26,929	0	0	0	0	0	0	0	0	0	26,929	21
22	Employee Benefits & Payroll Taxes	0	4,335	0	0	0	0	0	0	0	0	0	4,335	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**	(415)	31,264	0	0	0	0	0	0	0	0	0	30,849	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,066)	31,264	0	0	0	0	0	0	0	0	0	27,198	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STRIVE # 0036921 **Report Period Beginning:** 07/01/2024 **Ending:** 6/30/2025

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	(996)	0	0	0	0	0	0	0	0	0	0	(996)	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**	(996)	0	0	0	0	0	0	0	0	0	0	(996)	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)**	(5,062)	31,264	0	0	0	0	0	0	0	0	0	26,202	45

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 SNF	PROPHETSTOWN	LYNDON PROGRESS CENTER	LYNDON	DAY TREATMENT
		BIG MEADOWS (BUILDING ONLY)	SAVANNA	LYNDON PLAY AND LEARN	LYNDON	DAY CARE
		PINNACLE PLACE SLF	SAVANNA	FRONTIER HOLLOW APARTMENTS	PROPHETSTOWN	INDEPENDENT APARTMENTS

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V		ADMINISTRATIVE OVERHEAD		WINNING WHEELS INC (ADMINISTRATIVE FUND)	100.00%	26,929	26,929	5
6	V	21	CLERICAL SALARIES		(SEE DETAILS, SCHEDULE VIII, PAGE 8)		4,335	4,335	6
7	V	22	BENEFITS						7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 31,264	$ * 31,264	14

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

Lyndon Progress Center (LPC)
For The 12 Periods Ended 6/30/2025
90 ADMINISTRATION

EXPENSES			Wheels	STRIVE
5460-90	ADMINISTRATION	$ 262,116.00	$ 125,133.00	$ 26,929.00
6460-90	ADMINISTRATIVE	$ 22,225.00		
5620-90	FICA	$ 19,788.00	$ 8,708.00	$ 1,874.00
5640-90	WORKMAN'S COMP	$ 4,754.00	$ 2,092.00	$ 450.00
5650-90	UNEMPLOYMENT	$ 19.00	$ 8.00	$ 2.00
5660-90	LIFE INSURANCE	$ 340.00	$ 150.00	$ 32.00
5665-90	VISION INSURANCE	$ 239.00	$ 105.00	$ 23.00
5671-90	HEALTH INSURANCE	$ 16,815.00	$ 7,400.00	$ 1,592.00
5675-90	SUPPLEMENTAL INS	$ -	$ -	$ -
5685-90	DENTAL INSURANCE	$ 1,205.00	$ 530.00	$ 114.00
5690-90	ST & LT DISABILITY INS	$ 1,513.00	$ 666.00	$ 143.00
5695-90	VOL LIFE INS	$ -	$ -	$ -
5730-90	CHILD CARE	$ -	$ -	$ -
5750-90	OTHER	$ 1,105.00	$ 486.00	$ 105.00
Total EXPENSES:		$ 330,119.00	$ 145,278.00	$ 31,264.00

		% of Total Salaries and Benefits	Portion of LPC Salaries and Benefits
Winning Wheels			
Salaries	$ 4,283,813.00		$ 125,133.41
Benefits	$ 734,309.00		$ 20,146.08
Total Salaries and Benefits	$ 5,018,122.00	44.01%	$ 145,279.49
STRIVE			
Salaries	$ 902,720.00		$ 26,928.64
Benefits	$ 177,177.00		$ 4,335.43
Total Salaries and Benefits	$ 1,079,897.00	9.47%	$ 31,264.07
Day Treatment			
Salaries	$ 196,065.00		$ 5,882.77
Benefits	$ 39,847.00		$ 947.11
Total Salaries and Benefits	$ 235,912.00	2.07%	$ 6,829.88
Frontier Hollow			
Salaries	$ 176,757.00		$ 4,968.96
Benefits	$ 22,509.00		$ 799.99
Total Salaries and Benefits	$ 199,266.00	1.75%	$ 5,768.95
Day Care			
Salaries	$ 251,446.00		$ 7,594.85
Benefits	$ 53,124.00		$ 1,222.75
Total Salaries and Benefits	$ 304,570.00	2.67%	$ 8,817.60
Pinnacle Place			
Salaries	$ 405,858.00		$ 11,884.64
Benefits	$ 70,742.00		$ 1,913.39
Total Salaries and Benefits	$ 476,600.00	4.18%	$ 13,798.03
Big Meadows			
Salaries	$ 3,511,726.00		$ 101,947.72
Benefits	$ 576,599.00		$ 16,413.26
Total Salaries and Benefits	$ 4,088,325.00	35.85%	$ 118,360.98
Total			
Salaries	$ 9,728,385.00		**$ 284,340.99**
Benefits	$ 1,674,307.00		**$ 45,778.01**
Total Salaries and Benefits	**$ 11,402,692.00**	**100.00%**	**$ 330,119.00**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

STRIVE

ID# **0036921**

Report Period Beginning: **07/01/2024**

Ending: **6/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	NA								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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20									20
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65									65
66									66
67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

STRIVE

ID# **0036921**

Report Period Beginning: **07/01/2024**

Ending: **6/30/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
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139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT							2
3	TOM NANCE - VICE PRESIDENT							3
4	CONNIE DEMANRANVILLE							4
5	KYLE GIBSON - TREASURER							5
6	RICK TURNROTH							6
7	DEB ROBINSON							7
8	DAVE EYRICH							8
9	LINDA LEBLANC-PARKS							9
10	ALAN GAPINSKI							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: 07/01/2024 Ending: 6/30/2025

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	ADMINISTRATOR	ADMINISTRATOR		0.00		40	100.00	SAL/BEN	$ 196,991	17	1
2	CORPORATE	CFO, CEO, DIR OF OPS		0.00		10	20.00	SAL/BEN	12,710	17	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 209,701		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

American Health Enterprises, Inc. (AHE)
For The 9 Periods Ended 03/31/25
Expense Statement

	2024 Total from G/L	Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Home Office Allocation	AHE Corp	Total	
Expenses									
SALARIES									
5340 ADMINISTRATORS	$ 423,184	$ 98,073	$ 82,238	$ 179,435	$ 63,438			$ 423,184	$ -
5360 FINANCE	$ 130,946					$ 130,946	$ -	$ 130,946	$ -
5460 CORPORATE	$ 9,000	$ -	$ -	$ 9,000	$ -	$ -	$ -	$ 9,000	$ -
Total SALARIES:	$ 563,130	$ 98,073	$ 82,238	$ 188,435	$ 63,438	$ 130,946	$ -	$ 563,130	$ -
BENEFITS									
5620 FICA	$ 43,079	$ 7,503	$ 6,291	$ 14,415	$ 4,853	$ 10,017	$ -	$ 43,079	$ -
5640 WORKMENS COMP	$ 600	$ 104.49	$ 87.62	$ 200.77	$ 67.59	$ 139.52	$ -	$ 600	$ -
5650 UNEMPLOYMENT	$ 782	$ 136.19	$ 114.20	$ 261.67	$ 88.09	$ 181.84	$ -	$ 782	$ -
5660 HEALTH INS	$ 35,103	$ -	$ 9,984	$ 6,555	$ 12,345	$ 6,218	$ -	$ 35,103	$ 0
5690 401K	$ 8,160	$ 1,421.17	$ 1,191.71	$ 2,730.61	$ 919.28	$ 1,897.54	$ -	$ 8,160	$ -
5750 OTHER	$ 5,500					$ 5,500		$ 5,500	$ -
Total BENEFITS:	$ 93,225	$ 9,164	$ 17,669	$ 24,164	$ 18,273	$ 23,955	$ -	$ 93,225	$ 0
CONTRACT SERVICES									
6460 ADMINISTRATION	$ -					$ -		$ -	$ -
6470 DATA PROCESSING	$ 18,365					$ -	$ 18,365	$ 18,365	$ -
Total CONTRACT SERVICES:	$ 18,365	$ -	$ -	$ -	$ -	$ -	$ 18,365	$ 18,365	$ -
SUPPLIES									
7420 MAINTENANCE	$ -					$ -	$ -	$ -	$ -
7440 TRANSPORTATION	$ -					$ -	$ -	$ -	$ -
7460 OFFICE	$ -					$ -	$ -	$ -	$ -
7470 COMPUTER SUPPLIES	$ -					$ -	$ -	$ -	$ -
Total SUPPLIES:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GENERAL & ADMIN.									
8080 CABLE TV	$ -					$ -		$ -	$ -
9010 TELEPHONE	$ 5,564					$ -	$ 5,564	$ 5,564	$ (0)
9020 DUES & SUBSCRIPTIONS	$ 133					$ -	$ 133	$ 133	$ -
9040 INSURANCE	$ -					$ -		$ -	$ -
9080 POSTAGE	$ 73					$ -	$ 73	$ 73	$ -
9100 LEGAL & ACCOUNTING	$ -					$ -	$ -	$ -	$ -
9120 RECRUITMENT	$ -					$ -		$ -	$ -
9140 TRAVEL & SEMINAR	$ 1,364					$ -	$ 1,364	$ 1,364	$ -
9160 LICENSE & TAXES	$ 75						$ 75	$ 75	$ -
9170 DONATIONS						$ -		$ -	$ -
9180 OTHER	$ 15,381					$ -	$ 15,381	$ 15,381	$ (0)
9190 COMMUNITY RELATIONS	$ -					$ -		$ -	$ -
Total GENERAL & ADMIN.:	$ 22,591	$ -	$ -	$ -	$ -	$ -	$ 22,590	$ 22,590	$ (1)
INTEREST									
9340 INTEREST - AUTOS	$ -							$ -	$ -
Total INTEREST:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Expenses:	$ 697,310	$ 107,237	$ 99,907	$ 212,599	$ 81,711	$ 154,901	$ 40,955	$ 697,310	

Allocation to the Cost Reports		Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	
Revenues	$ 16,101,552	$ 8,176,227	$ 5,254,719	$ 1,562,851	$1,107,755	
		50.78%	32.63%	9.71%	6.88%	
Total Salary for benefit %	$ 563,130	$ 164,566	$ 124,972	$ 201,145	$ 72,447	
		29.22%	22.19%	35.72%	12.87%	Allocated to the facility cost reports
Employee Benefits	$ 23,953	$ 6,999	$ 5,316	$ 8,556	$ 3,082	$ 23,955
Home Office Costs	$ -	$ -	$ -	$ -	$ -	$ -
Administrator	$ 432,184	$ 98,073	$ 82,238	$ 188,435	$ 63,438	
Home Office Salaries	$ 130,946	$ 66,493	$ 42,734	$ 12,710	$ 9,009	$ 130,946
	$ 587,083	$ 171,565	$ 130,288	$ 209,701	$ 75,529	$ 154,901

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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: Lyndon Progress Center
Street Address: 501 6th Ave W
City / State / Zip Code: Lyndon IL 61261
Phone Number: (815-778-3683
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	11,402,692	7	$ 284,341	$	1,079,897	$ 26,929	1
2	22	FICA	SALARIES/BENEFITS	11,402,692	7	19,788		1,079,897	1,874	2
3	22	WORKERS COMP	SALARIES/BENEFITS	11,402,692	7	4,773		1,079,897	452	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	11,402,692	7	340		1,079,897	32	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	11,402,692	7	239		1,079,897	23	5
6	22	VISION INSURANCE	SALARIES/BENEFITS	11,402,692	7	16,815		1,079,897	1,592	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	11,402,692	7	1,205		1,079,897	114	7
8	22	ST & LT DISABILITY INC	SALARIES/BENEFITS	11,402,692	7	1,513		1,079,897	143	8
9	22	OTHER	SALARIES/BENEFITS	11,402,692	7	1,105		1,079,897	105	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					$ 330,119	$		$ 31,264	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2025 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

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.**

2024 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 #: 815-778-4503

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

FRONTIER HOLLOW APARTMENTS, INDEPENDENT LIVING APARTMENTS, 16 ONE BEDROOM UNITS

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? YES

H. Are you presently operating under a sale and leaseback arrangement? NO

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? NO

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [S] 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: 07/01/2024 Ending: 6/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	$ 377,675	$ 9,442	40	$ 9,442	$ (0)	$ 322,970	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING			1992	7,906	155	34	155		5,232	9
10	REMODELING			1993	2,920		20			2,920	10
11	REMODELING			1995	2,556		14			25,556	11
12	REMODELING			1996	1,805		15			1,805	12
13	REMODELING			1997	38,293	240	15	240		38,533	13
14	REMODELING			1998	5,075		12.5			5,075	14
15	REMODELING			1999	5,386		15			5,386	15
16	REMODELING			2000	6,085		15			6,085	16
17	REMODELING			2001	42,570	1,092	21.89	1,092		42,570	17
18	REMODELING			2002	96,262	3,061	13	3,061		95,995	18
19	REMODELING			2005	4,270		15			4,270	19
20	REMODELING			2006	177,391	5,766	18.5	5,766		111,551	20
21	REMODELING			2008	928		7			928	21
22	REMODELING			2010	16,840		7.33			16,840	22
23	REPLACE WALL CARPET THROUGH BUILDING			2010	5,208		7			5,208	23
24	ROOF ON MAIN BUILDING			2010	16,654	1,101	15	1,101		16,654	24
25	PAINTING MAIN HALLWAY AND DINING ROOM			2011	3,196		7			3,196	25
26	FLOORING AND WALL CARPET IN MAIN HALLWAYS			2012	5,212		5			5,212	26
27	CARPET IN FOUR RESIDENT ROOMS			2012	4,101		7			4,101	27
28	WIRING FOR GENERATOR PREPARATION			2014	10,750	538	7	538		6,005	28
29	TANKLESS WATER HEATER			2021	3,201	107	10	107		535	29
30	GARAGE ROOF MATERIALS			2021	1,389	23	10	23		95	30
31	PARKING LOT DRAINAGE			2022	19,950	1,663	10	1,663		6,652	31
32	PARKING LOT DRAINAGE			2022	104,318	5,795	5	5,795		23,180	32
33	FRONT SIDEWALK FENCE			2022	5,394	514	7	514		2,056	33
34	YORK 95 SINGLE STAGE			2022	5,022	251	10	251		1,004	34
35	DRY PENDENT SPRINKLER HEADS			2022	15,669	653	10	653		2,612	35
36					986,026	30,401	373	30,401		762,226	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: 07/01/2024 Ending: 6/30/2025

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	SHOWER REDO	2023	$ 5,807	$ 97	10	$ 97	$	$ 291	37
38	VINYL FLOORING	2024	4,325	216	10	433	217	216	38
39	PORTABLE GENERATOR	2025	25,000	2,500	10	2,500		2,500	39
40	NEW YORK 16 SEER CONDENSER	2025	5,467		10	547	547		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)		$ 1,026,625	$ 33,214		$ 33,978	$ 764	$ 765,233	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: 07/01/2024 Ending: 6/30/2025

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	$ 75,300	$ 11,746	$ 11,746	$	7	$ 318,214	71
72	Current Year Purchases	2,552	610	843	233	7	610	72
73	Fully Depreciated Assets	317,559					317,559	73
74								74
75	TOTALS	$ 395,411	$ 12,356	$ 12,589	$ 233		$ 636,383	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 OUTING	2009 FORD SHUTTLE	2008	$ 56,975	$	$	$		$ 56,975	76
77										77
78										78
79										79
80	TOTALS			$ 56,975	$	$	$		$ 56,975	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)	$ 1,547,962	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,570	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 46,567	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 997	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,458,591	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: 07/01/2024 Ending: 6/30/2025

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.	/2026	$
13.	/2027	$
14.	/2028	$

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: 07/01/2024 Ending: 6/30/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number STRIVE

STATE OF ILLINOIS
0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10.3	25 # of prescrpts	1,280				25	1,280	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): PSYCHOLOGICAL	103		1,350					1,350	12
13	Other (specify):									13
14	TOTAL			$ 2,630		$	$	25	$ 2,630	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: 07/01/2024 Ending: 6/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2025 (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	$ 5,800	$ 422,781	1
2	Cash-Patient Deposits	28,740	103,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,200)	129,269	1,137,163	3
4	Supply Inventory (priced at COST)	9,400	6,730	4
5	Short-Term Investments			5
6	Prepaid Insurance		26,366	6
7	Other Prepaid Expenses		113,600	7
8	Accounts Receivable (owners or related parties)		39,625	8
9	Other(specify):		184,542	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 173,209	$ 2,034,685	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,951	218,708	13
14	Buildings, at Historical Cost	1,026,625	16,775,449	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	452,386	5,668,030	16
17	Accumulated Depreciation (book methods)	(1,458,591)	(15,060,986)	17
18	Deferred Charges	10,949	22,166	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		167,367	20
21	Restricted Funds		652,409	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LEASE ASSETS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 100,320	$ 8,443,143	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 273,529	$ 10,477,828	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,961	$ 1,228,531	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,740	99,503	28
29	Short-Term Notes Payable		415,575	29
30	Accrued Salaries Payable	85,370	874,889	30
31	Accrued Taxes Payable (excluding real estate taxes)		126,167	31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,018	32
33	Accrued Interest Payable		12,235	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LEASES		71,614	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 234,071	$ 2,890,532	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,479,803	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LEASES		144,452	43
44	PAID IN CAPITAL		32,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,656,255	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 234,071	$ 6,546,787	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 39,458	$ 3,931,041	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 273,529	$ 10,477,828	48

***(See instructions.)**

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,350,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,350,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,458	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) RELATED FACILITIES	(1,459,082)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,419,624)	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)**	$ 3,931,041	24 *

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	$ 1,652,547	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,651,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,764	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,764	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	HAB AIDE TRAINING	4,583	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,583	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,660,694	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	191,935	31
32	Health Care	774,001	32
33	General Administration	512,870	33
	B. Capital Expense		
34	Ownership	44,574	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	97,856	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,621,236	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,458	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,458	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,652,547.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,652,547	56

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	240	240	9,480	39.50	3
4	Licensed Practical Nurses	1,695	1,922	63,004	32.78	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,144	2,438	64,413	26.42	9
10	Activity Assistants	200	200	3,000	15.00	10
11	Social Service Workers	1,640	1,882	55,148	29.30	11
12	Dietician					12
13	Food Service Supervisor	425	570	9,286	16.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,046	1,134	16,186	14.27	15
16	Dishwashers					16
17	Maintenance Workers	645	700	12,404	17.72	17
18	Housekeepers	2,119	2,266	36,917	16.29	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,778	2,053	53,835	26.22	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,697	26,624	557,511	20.94	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) ADMINISTRATO	782	887	21,535	24.28	33
34	TOTAL (lines 1 - 33)	35,411	40,916	$ 902,719 *	$ 22.06	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	25	1,280	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)				46
47	PSYCHOLOGICAL	2	1,350	15.3	47
48					48
49	TOTAL (lines 35 - 48)	27	$ 2,630		49

C. CONTRACT NURSES

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

Facility Name & ID Number STRIVE # 0036921 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNE DUNBAR	ADMIN	0	$ 179,435
MYRIAH DROLEMA	ADMIN	0	21,535
(DUNBAR INCLUDED IN AMERICAN			
HEALTH ENTERPRISES IN BELOW)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,970

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 80,250
PLYMOUTH MANAGEMENT SERVICES	17,894
TOTAL (agree to Schedule V, line 17, col. 3)	$ 98,144
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
POINTCLICKCARE	RESIDENT SOFTWARE	$ 8,473
JOHN PYSE CONSULT	IT CONSULTANT	3,780
MARCUM	AUDIT FIRM	16,056
MIDWEST AUTO TIME	TIMECLOCK SOFTWARE	2,640
INOVALON	BILLING SOFTWARE	4,170
CDW GOVT INC	IT SOFTWARE	875
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 35,994

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,161
Unemployment Compensation Insurance	114
FICA Taxes	68,445
Employee Health Insurance	60,072
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	1,389
DISABILITY INSURANCE	4,280
CHILD CARE	6,534
DENTAL / VISION INSURANCE	7,020
PHYSICALS / DRUG TEST	343
TUITION ASSIST	126
OTHER / EMP BANQUET / XMAS GIFTS	10,693
TOTAL (agree to Schedule V, line 22, col.8)	$ 177,177

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	906
Health Care Worker Background Check	400
(Indicate # of checks performed 8)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	1,385
COMMUNITY RELATIONS	2,099
Less: Public Relations Expense	( )
PAC and Lobbying payments	(415)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,375

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
HOTEL	285
TRAVEL	149
Seminar Expense	375
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 809

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	970
	970 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	415
	415 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	1,385
	1,385 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 4,996 Line 10

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

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

(8) 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.

(9) 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

(10) 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.

(11) 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. $

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? 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? Indicate the amount of income earned from providing such transportation during this reporting period. $

(13) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: RKL

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

(15) 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

Report Period Beginning 7/1/2023

Report Period Ending 6/30/2024

			In State	Out of State
	DETAIL SCHEDULE - V-LINE 24			
1	Name & Title	Toni Williar		
	Date of Seminar	10/3/2023 - 10/4/2023		
	Location	Bloomington, IL		
	Title of Seminar	Annual Conference		
	Sponsor	IAPA Conference		
	Cost	$335 CONFERENCE / $285 HOTEL / $149 TRAVEL	$769.00	
2	Name & Title	Katrina Gerber		
	Date of Seminar	3/5/2025		
	Location	NAPERVILLE IL		
	Title of Seminar	Annual Conference		
	Sponsor	ICPN CONFERENCE		
	Cost	$40 CONFERENCE	$40.00	
			$809.00	
		Total Seminars	$375.00	
		Less: Out of State Travel & Seminars	$0.00	
		Total Travel and Seminars	$375.00	
				$0.00
	Total - Schedule V, Line 24 - Other		$375.00	
	Total - Schedule V, Line 24 - Adjustments		$0.00	
	Total - Schedule V, Line 24 - 8		$375.00	

TRAINING
07/01/2024 - 6/30/2025

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
7/31/2024	RELIAS	4,076.00	ONLINE TRAINING
		4,076.00	