

Facility Name & ID Number DIAMONDVIEW# 0038638 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,669</u>			<u>5,669</u>
14	TOTALS	<u>5,669</u>			<u>5,669</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.81%

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

21 (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)

NONEF. 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

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 05/03/93

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/03/93 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

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 7/1/07-6/30/08 Fiscal Year: 7/1/07-6/30/08

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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	28,669	3,031	1,697	33,397	4,423	37,820	37,820			1
2	Food Purchase		41,412		41,412		41,412	41,412			2
3	Housekeeping		3,615		3,615	13,265	16,880	16,880			3
4	Laundry		1,356		1,356	8,844	10,200	10,200			4
5	Heat and Other Utilities			22,724	22,724	(2,932)	19,792	19,792			5
6	Maintenance	4,648	1,482	4,257	10,387		10,387	10,387			6
7	Other (specify):* TRASH SERVICE					2,932	2,932	2,932			7
8	TOTAL General Services	33,317	50,896	28,678	112,891	26,532	139,423	139,423			8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200	1,200			9
10	Nursing and Medical Records	228,050	8,474	6,969	243,493	(31,896)	211,597	211,597			10
10a	Therapy			2,593	2,593		2,593	2,593			10a
11	Activities	7,901	2,457		10,358	5,364	15,722	15,722			11
12	Social Services			1,560	1,560		1,560	1,560			12
13	CNA Training	5,642	109		5,751		5,751	5,751			13
14	Program Transportation		5,005		5,005		5,005	5,005			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	241,593	16,045	12,322	269,960	(26,532)	243,428	243,428			16
	C. General Administration										
17	Administrative	22,111			22,111		22,111	22,111			17
18	Directors Fees										18
19	Professional Services			35,613	35,613		35,613	35,613			19
20	Dues, Fees, Subscriptions & Promotions			58,301	58,301		58,301	(50,000)	8,301		20
21	Clerical & General Office Expenses		5,492		5,492		5,492	5,492			21
22	Employee Benefits & Payroll Taxes			62,983	62,983		62,983	62,983			22
23	Inservice Training & Education										23
24	Travel and Seminar			430	430		430	430			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,488	9,488		9,488	9,488			26
27	Other (specify):*										27
28	TOTAL General Administration	22,111	5,492	166,815	194,418		194,418	(50,000)	144,418		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	297,021	72,433	207,815	577,269		577,269	(50,000)	527,269		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 DIAMONDVIEW

#0038638

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			29,016	29,016	29,016		29,016			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			26,914	26,914	26,914	(25,066)	1,848			32
33	Real Estate Taxes			528	528	528		528			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* TRUSTEE/BOND FEES			3,160	3,160	3,160		3,160			36
37	TOTAL Ownership			59,618	59,618	59,618	(25,066)	34,552			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			39,582	39,582	39,582		39,582			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			39,582	39,582	39,582		39,582			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	297,021	72,433	307,015	676,469	676,469	(75,066)	601,403			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 DIAMONDVIEW

0038638

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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.)

		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				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	25,066	32		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	50,000	20		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				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)	\$ 75,066		\$	30

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 75,066		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.

		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

BHF USE ONLY						
48		49		50		51
						52

DIAMONDVIEW

ID# 0038638

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DIAMONVIEW# 0038638

Report Period Beginning:

07/01/2007

Ending:

06/30/2008**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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	50,000	0	0	0	0	0	0	0	0	0	0	50,000	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	50,000	0	0	0	0	0	0	0	0	0	0	50,000	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	50,000	0	0	0	0	0	0	0	0	0	0	50,000	29

STATE OF ILLINOIS

Facility Name & ID Number DIAMONDDVIEW

0038638

Report Period Beginning:

07/01/2007 Ending:

Summary B

06/30/2008

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	25,066	0	0	0	0	0	0	0	0	0	0	25,066	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	25,066	0	25,066	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)	75,066	0	75,066	45									

Facility Name & ID Number DIAMONDVIEW

0038638

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LYNWOOD ESTATES	SALEM			
		COLONIAL APARTMENTS	CENTRALIA			
		PARK PLACE	CENTRALIA			

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

DIAMONDVIEW

#

0038638

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number DIAMONDVIEW

0038638 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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

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

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

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	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	ILL DEV FINANCE AUTHORITY	X	MORTGAGE	APPR5029	7/02/97	\$ 684,800	\$ 395,200	7/1/2014	0.0623	\$ 26,914	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 684,800	\$ 395,200			\$ 26,914	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 684,800	\$ 395,200			\$ 26,914	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DIAMONDVIEW COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0038638

CONTACT PERSON REGARDING THIS REPORT RENEE ZIEGLER

TELEPHONE 618 533-9633 EXT 4 FAX #: 618 533-6345

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-00-080-500</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>33.54</u>	\$ <u>33.54</u>
2. <u>14-00-080-505</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>34.34</u>	\$ <u>34.34</u>
3. <u>14-00-080-510</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>39.94</u>	\$ <u>39.94</u>
4. <u>14-00-080-515</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>41.52</u>	\$ <u>41.52</u>
5. <u>14-00-080-520</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>39.94</u>	\$ <u>39.94</u>
6. <u>14-00-080-525</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>39.94</u>	\$ <u>39.94</u>
7. <u>14-00-080-531</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>56.70</u>	\$ <u>56.70</u>
8. <u>14-00-080-536</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>25.56</u>	\$ <u>25.56</u>
9. <u>14-00-080-541</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>13.58</u>	\$ <u>13.58</u>
10. <u>14-00-080-546</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>25.56</u>	\$ <u>25.56</u>
	TOTALS	\$ <u>350.62</u>	\$ <u>350.62</u>

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? X YES NO

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number DIAMONDVIEW

0038638 Report Period Beginning:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,560 B. General Construction Type: Exterior BRICK Frame WOOD 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).

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>INCLUDED</u>	<u>50,000</u>	<u>1995</u>	\$	1
2			<u>1999</u>		2
3	TOTALS	50,000		\$	3

Facility Name & ID Number **DIAMONDVIEW**

0038638

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		1995	1995	\$ 397,582	\$ 15,903	25	\$ 15,903	\$	\$ 214,751	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	PARKING LOT			2002	3,500	140	25	140		852	9
10	STEEL DOOR			2005	1,003	40	25	40		140	10
11	GENERATOR			2008	20,000	333	10	333		333	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

*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 **DIAMONDVIEW**

0038638

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)	\$	422,085	\$	16,416	\$	16,416	\$	216,076	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 17,473	\$ 2,848	\$ 2,848	\$	5	\$ 93,249	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	83,604						73
74								74
75	TOTALS	\$ 101,077	\$ 2,848	\$ 2,848	\$		\$ 93,249	75

D. Vehicle Depreciation (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	PATIENT/ADMIN	2005 GMC SAVANA	2005	\$ 41,324	\$ 8,265	\$ 8,265	\$	5	\$ 24,106	76
77	PATIENT/ADMIN	2001 PONTIAC MONTANA	2005	7,435	1,487	1,487		5	3,965	77
78										78
79										79
80	TOTALS			\$ 48,759	\$ 9,752	\$ 9,752	\$		\$ 28,071	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)	\$ 571,921	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,016	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,016	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)	\$ 337,396	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 DIAMONDVIEW

0038638

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		109		109
3	Classroom Wages (a)		1,613		1,613
4	Clinical Wages (b)		3,226		3,226
5	In-House Trainer Wages (c)		803		803
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,751	\$	\$ 5,751
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,751		

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescripts							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.

Facility Name & ID Number DIAMONDVIEW# 0038638Report Period Beginning: 07/01/2007

Ending:

06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(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	\$ 2,012,634	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	769,652		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,075		6
7	Other Prepaid Expenses	48,498		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM PENTA GROUP</u>	189,224		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,023,083	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,406		13
14	Buildings, at Historical Cost	1,701,459		14
15	Leasehold Improvements, at Historical Cost	71,673		15
16	Equipment, at Historical Cost	785,655		16
17	Accumulated Depreciation (book methods)	(1,400,097)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	457,429		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>BOND ISSUANCE</u>	27,757		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,753,282	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,776,365	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,541	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	146,529		29
30	Accrued Salaries Payable	66,006		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,974		31
32	Accrued Real Estate Taxes(Sch.IX-B)	848		32
33	Accrued Interest Payable	36,865		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 328,763	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	296,602		39
40	Mortgage Payable			40
41	Bonds Payable	1,115,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>PREMIUM ON BONDS</u>	278		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,411,880	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,740,643	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,035,722	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,776,365	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,249,183	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,249,183	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(213,461)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (213,461)	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)	\$ 3,035,722	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number DIAMONDVIEW# 0038638Report Period Beginning: 07/01/2007Ending: 06/30/2008**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 683,498	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 683,498	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	8,800	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)	\$ 8,800	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(25,783)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (25,783)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	15,973	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,973	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 682,488	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	112,891	31
32	Health Care	269,960	32
33	General Administration	194,418	33
B. Capital Expense			
34	Ownership	59,618	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	39,582	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 676,469	40
41	Income before Income Taxes (line 30 minus line 40)**	6,019	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 6,019	43

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

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

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

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

Facility Name & ID Number **DIAMONDDVIEW**

0038638

Report Period Beginning: **07/01/2007**

Ending:

06/30/2008

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	2,165	2,210	26,472	11.98	4
5	CNAs & Orderlies					5
6	CNA Trainees	520	520	5,642	10.85	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,475	1,560	13,265	8.50	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,987	2,118	28,669	13.54	14
15	Cook Helpers/Assistants	492	520	4,422	8.50	15
16	Dishwashers					16
17	Maintenance Workers	440	455	4,648	10.22	17
18	Housekeepers	1,475	1,560	13,265	8.50	18
19	Laundry	984	1,040	8,844	8.50	19
20	Administrator	480	520	22,111	42.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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	1,767	1,918	35,664	18.59	29
30	Habilitation Aides (DD Homes)	15,052	15,944	134,019	8.41	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,837	28,365	\$ 297,021 *	\$ 10.47	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	24	\$ 1,697	1-3	35
36	Medical Director	12	1,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	31	1,094	10-3	38
39	Pharmacist Consultant	12	600	10-3	39
40	Physical Therapy Consultant	7	514	10A-3	40
41	Occupational Therapy Consultant	10	777	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	819	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,560	12-3	45
46	Other(specify)				46
47	DENTAL/VISION	70	5,276	10-3	47
48	PSYCHOLOGIST	5	482	10A-3	48
49	TOTAL (lines 35 - 48)	215	\$ 14,019		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **DIAMONDVIEW**

0038638

Report Period Beginning: **07/01/2007**

Ending: **06/30/2008**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
GEORGIA MILLER	CEO		\$ 22,111	Workers' Compensation Insurance	\$ 18,802	IDPH License Fee	\$		
				Unemployment Compensation Insurance	1,022	Advertising: Employee Recruitment	2,944		
				FICA Taxes	22,165	Health Care Worker Background Check	304		
				Employee Health Insurance	15,249	(Indicate # of checks performed <u>19</u>)			
				Employee Meals		Patient Background Checks	0		
				Illinois Municipal Retirement Fund (IMRF)*		SUBSCRIPTIONS	1,416		
				FLOWERS,HOLIDAY PARTIES,VACCINES, PHYSICALS,RETIREMENT	5,745	DUES	3,497		
						LICENSE & FEES	140		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 22,111						
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				Less: Public Relations Expense ()		
			\$				Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
CATCHALL SERVICES	ADMIN		\$ 32,372			\$	Out-of-State Travel	\$	
CRAIN, MILLER & WERNSMAN	LEGAL		300						
GLASS & SHUFFETT	AUDIT		1,729				In-State Travel		
CREATIVE SYSTEMS	COMPUTER		1,099						
S MILNER	CLERICAL		113				Seminar Expense		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 35,613	TOTAL			\$	Entertainment Expense () (agree to Sch. V, line 24, col. 8)	
							TOTAL		\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IARF - 3497
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 665 Line 10-2
- (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. \$ 39,582
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? YES 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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 80
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? N/A
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? _____
Firm Name: GLASS & SHUFFETT The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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.

PAGE 10A
DIAMONDVIEW
IDPH LICENSE NUMBER 0038638

TAX INDEX NUMBER	PROPERTY DESCRIPTION	TOTAL TAX	APPLICABLE TAX
14-00-080-550	COUNTRY CLUB ROAD SUB LOT 11	\$33.54	\$33.54
14-00-080-555	COUNTRY CLUB ROAD SUB LOT 12	\$38.34	\$38.34
14-00-080-565	COUNTRY CLUB ROAD SUB LOT 14	\$28.76	\$28.76
14-00-080-570	COUNTRY CLUB ROAD SUB LOT 15	\$28.76	\$28.76
14-00-080-575	COUNTRY CLUB ROAD SUB LOT 16	\$28.76	\$28.76

2007

14-00-080-500	COUNTRY CLUB ROAD SUB LOT 1	\$36.40	\$36.40
14-00-080-505	COUNTRY CLUB ROAD SUB LOT 2	\$37.20	\$37.20
14-00-080-510	COUNTRY CLUB ROAD SUB LOT 3	\$42.86	\$42.86
14-00-080-515	COUNTRY CLUB ROAD SUB LOT 4	\$44.48	\$44.48
14-00-080-520	COUNTRY CLUB ROAD SUB LOT 5	\$42.86	\$42.86
14-00-080-525	COUNTRY CLUB ROAD SUB LOT 6	\$42.86	\$42.86
14-00-080-531	COUNTRY CLUB ROAD SUB LOT 7	\$61.46	\$61.46
14-00-080-536	COUNTRY CLUB ROAD SUB LOT 8	\$27.50	\$27.50
14-00-080-541	COUNTRY CLUB ROAD SUB LOT 9	\$14.56	\$14.56
14-00-080-546	COUNTRY CLUB ROAD SUB LOT 10	\$27.50	\$27.50
14-00-080-550	COUNTRY CLUB ROAD SUB LOT 11	\$36.40	\$36.40
14-00-080-555	COUNTRY CLUB ROAD SUB LOT 12	\$41.24	\$41.24
14-00-080-565	COUNTRY CLUB ROAD SUB LOT 14	\$30.74	\$30.74
14-00-080-570	COUNTRY CLUB ROAD SUB LOT 15	\$30.74	\$30.74
14-00-080-575	COUNTRY CLUB ROAD SUB LOT 16	\$30.74	\$30.74

B.
50% APPLIES TO DIAMONDVIEW AND 50% APPLIES TO
PARK PLACE (IDPH LICENSE #0038646)

BOARD OF DIRECTORS

PENTA NASCENT CORP.
DIAMONDDVIEW

Don Middleton - President
6 Gayla Drive
Centralia, IL 62801

Allison Austin - Director
627 East Broadway
Centralia, IL 62801

Randy Vogt - Director
612 Cottonwood
Salem, IL 62881

Ed Sanders - Director
1827 South Lincoln
Centralia, IL 62801

Mark Mitchell - Director
401 Clarida
Centralia, IL 62801

SALARY ALLOCATIONS
 DIAMONDVIEW - 0038638
 YEAR ENDING 6-30-08

		SALARIES PER GL	%	TOTAL HOURS	VACATION S HRS, ETC
HOUSEKEEPING	\$0.00	\$0.00	0.00%	0.00	0.00
DIRECT CARE	\$8.51	\$171,556.89	95.60%	20159.00	1106.00
ACTIVITY	\$8.36	\$7,901.20	4.40%	945.00	40.00
SOC SERV	\$0.00	\$0.00	0.00%	0.00	0.00
CLERICAL	\$0.00	\$0.00	0.00%	0.00	0.00
	\$8.50	\$179,458.09	100.00%	21104.00	1146.00

	ALLOC HRS DAY	COST RPT	%	TOTAL HOURS	TOTAL HOURS WORKED
HOUSEKEEPING	6	\$13,265.48	7.39%	1560.00	1475.29
ACTIVITY	6	\$13,265.48	7.39%	1560.00	1475.29
LAUNDRY	4	\$8,843.65	4.93%	1040.00	983.53
COOK HELPER	2	\$4,421.83	2.46%	520.00	491.76
DIRECT CARE		\$139,661.65	77.83%	16424.00	15532.13
		\$179,458.09	100.00%	21104.00	19958.00