FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0038638

Facility Name: DIAMONDVIEW

Address: 338 COUNTRY CLUB ROAD (Number) CENTRALIA (City) 62801 (Zip Code)

County: MARION

Telephone Number: 618 532-9630 **Fax #** 618 532-9605

HFS ID Number:

Date of Initial License for Current Owners: 5/3/93

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: RENEE ZIEGLER **Telephone Number:** 618 533-9633
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 7/1/2009 to 6/30/2010 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) 9/27/10 (Date)
(Type or Print Name) JULIE CLARK
(Title) ADMINISTRATOR

Paid Preparer

(Signed) 9/27/10 (Date)
(Print Name and Title) RENEE ZIEGLER
(Firm Name & Address) CSI, P.O. BOX 1946, CENTRALIA, IL 62801
(Telephone) 618 533-9633 Fax # 618 533-6345

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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,258			5,258	13
14	TOTALS	5,258			5,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.03%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/03/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/03/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 7/1/09 - 6/30/10 Fiscal Year: 7/1/09 - 6/30/10

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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	25,505	4,468	1,872	31,845	4,566	36,411		36,411			1
2	Food Purchase		46,006		46,006		46,006		46,006			2
3	Housekeeping		3,778		3,778	13,697	17,475		17,475			3
4	Laundry		2,217		2,217	9,131	11,348		11,348			4
5	Heat and Other Utilities			24,485	24,485	(3,329)	21,156		21,156			5
6	Maintenance	5,087	4,194	6,191	15,472		15,472		15,472			6
7	Other (specify):* TRASH SERVICE					3,329	3,329		3,329			7
8	TOTAL General Services	30,592	60,663	32,548	123,803	27,394	151,197		151,197			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	249,843	9,677	5,093	264,613	(34,425)	230,188		230,188			10
10a	Therapy			3,203	3,203		3,203		3,203			10a
11	Activities	6,666	2,383		9,049	7,031	16,080		16,080			11
12	Social Services			1,560	1,560		1,560		1,560			12
13	CNA Training	2,016			2,016		2,016		2,016			13
14	Program Transportation		3,328		3,328		3,328		3,328			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	258,525	15,388	11,056	284,969	(27,394)	257,575		257,575			16
	C. General Administration											
17	Administrative	22,971			22,971		22,971		22,971			17
18	Directors Fees											18
19	Professional Services			36,312	36,312		36,312		36,312			19
20	Dues, Fees, Subscriptions & Promotions			5,338	5,338		5,338		5,338			20
21	Clerical & General Office Expenses		6,088		6,088		6,088		6,088			21
22	Employee Benefits & Payroll Taxes			58,286	58,286		58,286		58,286			22
23	Inservice Training & Education			55	55		55		55			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			9,410	9,410		9,410		9,410			26
27	Other (specify):*											27
28	TOTAL General Administration	22,971	6,088	109,401	138,460		138,460		138,460			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	312,088	82,139	153,005	547,232		547,232		547,232			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: 7/1/2009 Ending: 6/30/2010

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			29,750	29,750		29,750		29,750			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,232	22,232		22,232	(11,309)	10,923			32
33	Real Estate Taxes			272	272		272		272			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* BOND/TRUSTEE FEES			2,939	2,939		2,939		2,939			36
37	TOTAL Ownership			55,193	55,193		55,193	(11,309)	43,884			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			36,592	36,592		36,592		36,592			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,592	36,592		36,592		36,592			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	312,088	82,139	244,790	639,017		639,017	(11,309)	627,708			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: 7/1/2009 Ending: 6/30/2010

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				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	11,309	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				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)**	$ 11,309		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 11,309		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

DIAMONDVIEW

ID# 0038638

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DIAMONDVIEW **#** 0038638 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DIAMONDVIEW # 0038638 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Capital Expense D. Ownership	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)	
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	11,309	0	0	0	0	0	0	0	0	0	0	11,309	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**	11,309	0	0	0	0	0	0	0	0	0	0	11,309	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)**	11,309	0	0	0	0	0	0	0	0	0	0	11,309	45

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 [X] 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								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: 7/1/2009 Ending: 6/30/2010

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: 7/1/2009 Ending: 6/30/2010

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 [X]

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
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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	APPR5158	7/2/97	$ 684,800	$ 315,200	7/1/2014	0.0623	$ 22,232	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 684,800	$ 315,200			$ 22,232	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	$ 315,200			$ 22,232	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 DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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.)		$ 272	2
3. Under or (over) accrual (line 2 minus line 1).		$ 272	3
4. Real Estate Tax accrual used for 2010 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.		$ 272	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	254	9
2007	274	10
2008	276	11
2009	272	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 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 FAX #: 618 533-6345

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-00-080-500	COUNTRY CLUB ROAD SUB LOT	$ 36.12	$ 36.12
2.	14-00-080-505	COUNTRY CLUB ROAD SUB LOT	$ 36.94	$ 36.94
3.	14-00-080-510	COUNTRY CLUB ROAD SUB LOT	$ 42.68	$ 42.68
4.	14-00-080-515	COUNTRY CLUB ROAD SUB LOT	$ 44.32	$ 44.32
5.	14-00-080-520	COUNTRY CLUB ROAD SUB LOT	$ 42.68	$ 42.68
6.	14-00-080-525	COUNTRY CLUB ROAD SUB LOT	$ 42.68	$ 42.68
7.	14-00-080-531	COUNTRY CLUB ROAD SUB LOT	$ 60.74	$ 60.74
8.	14-00-080-536	COUNTRY CLUB ROAD SUB LOT	$ 27.08	$ 27.08
9.	14-00-080-541	COUNTRY CLUB ROAD SUB LOT	$ 14.78	$ 14.78
10.	14-00-080-546	COUNTRY CLUB ROAD SUB LOT	$ 27.08	$ 27.08
		TOTALS	$ 375.10	$ 375.10

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 7/1/2009 Ending: 6/30/2010

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? [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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		50,000	1995	$ 15,430	1
2			1999		2
3	TOTALS	50,000		$ 15,430	3

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$	$ 246,557	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT			2002	3,500	140	25	140		1,132	9
10	STEEL DOOR			2005	1,003	40	25	40		221	10
11	GENERATOR			2008	20,000	2,000	10	2,000		4,333	11
12	CARPET			2002	6,252		5			6,252	12
13	SPRINKLER SYSTEM			2010	6,043	34	15	34		34	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: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 434,380	$ 18,117		$ 18,117	$	$ 258,529	70

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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 9,407	$ 1,881	$ 1,881	$	5	$ 5,644	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	85,418					85,418	73
74								74
75	TOTALS	$ 94,825	$ 1,881	$ 1,881	$		$ 91,062	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	$ 40,635	76
77	PATIENT/ADMIN	2001 PONTIAC MONTANA	2005	7,435	1,487	1,487		5	6,939	77
78										78
79										79
80	TOTALS			$ 48,759	$ 9,752	$ 9,752	$		$ 47,574	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)	$ 593,394	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,750	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,750	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)	$ 397,165	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: 7/1/2009 Ending: 6/30/2010

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.	/2011	$
13.	/2012	$
14.	/2013	$

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 DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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? [X] YES [ ] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER CNA	60

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)		806		806
4	Clinical Wages (b)		1,210		1,210
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,016	$	$ 2,016
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,016			

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

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2010 (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	$ 615,327	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,039,089		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,216		6
7	Other Prepaid Expenses	27,746		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,695,378	$	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	111,396		15
16	Equipment, at Historical Cost	790,060		16
17	Accumulated Depreciation (book methods)	(1,648,794)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	454,677		21
22	Other Long-Term Assets (spe BOND ISSUANCE	18,504		22
23	Other(specify): DEU FROM PENTA GROUP	1,255,536		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,792,244	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,487,622	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,677	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	173,125		29
30	Accrued Salaries Payable	73,840		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,513		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	29,550		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)**	$ 401,705	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	233,707		39
40	Mortgage Payable			40
41	Bonds Payable	845,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PREMIUM ON BONDS	185		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,078,892	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,480,597	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,007,025	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,487,622	$	48

***(See instructions.)**

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,786,621	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,786,621	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,404	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)**	$ 220,404	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)**	$ 3,007,025	24 *

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

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 649,209	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 649,209	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	3,115	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,115	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,104	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,104	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	12,743	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,743	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 714,171	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	123,803	31
32	Health Care	284,969	32
33	General Administration	138,460	33
	B. Capital Expense		
34	Ownership	55,193	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,592	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 639,017	40
41	**Income before Income Taxes (line 30 minus line 40)****	75,154	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 75,154	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 DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	330	350	6,347	18.13	4
5	CNAs & Orderlies					5
6	CNA Trainees	200	200	2,016	10.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,538	1,560	13,696	8.78	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,868	2,133	25,505	11.96	14
15	Cook Helpers/Assistants	513	520	4,566	8.78	15
16	Dishwashers					16
17	Maintenance Workers			5,087		17
18	Housekeepers	1,538	1,560	13,696	8.78	18
19	Laundry	1,025	1,040	9,131	8.78	19
20	Administrator	480	520	22,971	44.18	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)	2,020	2,080	35,482	17.06	28
29	Resident Services Coordinator	19,520	19,801	173,591	8.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	29,032	29,764	$ 312,088 *	$ 10.49	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	27	$ 1,872	1-3	35
36	Medical Director	12	1,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	47	2,833	10-3	38
39	Pharmacist Consultant	12	600	10-3	39
40	Physical Therapy Consultant	8	695	10A-3	40
41	Occupational Therapy Consultant	5	422	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	1,445	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,560	12-3	45
46	Other(specify)				46
47	PSYCHOLOGIST	7	641	10A-3	47
48	DENTAL/VISION	21	1,660	10-3	48
49	TOTAL (lines 35 - 48)	195	$ 12,928		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 DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGIA MILLER	CEO		$ 22,971
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 22,971

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
CATCHALL SERVICES	ADMIN	$ 32,844
CRAIN, MILLER & WERNSMAN	LEGAL	479
GLASS & SHUFFETT	AUDIT	1,806
CREATIVE SYSTEMS	COMPUTER	1,108
S MILNER	CLERICAL	75
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 36,312

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,321
Unemployment Compensation Insurance	73
FICA Taxes	22,848
Employee Health Insurance	13,782
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
FLOWERS, HOLIDAY PARTIES, VACCINES,	
PHYSICALS, RETIREMENT	5,262
TOTAL (agree to Schedule V, line 22, col.8)	$ 58,286

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	1,032
Health Care Worker Background Check	384
(Indicate # of checks performed 24)	
Patient Background Checks	
SUBSCRIPTIONS	215
DUES	3,498
LICENSE & FEES	209
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,338

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number DIAMONDVIEW # 0038638 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

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

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IARF - 3498**

(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. $ **0** Line _____

(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. $ **36,592**
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? **YES**
Firm Name: **GLASS & SHUFFETT**

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

(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.

BOARD OF DIRECTORS

PENTA NASCENT CORP
DIAMONDVIEW

ALLISON AUSTIN - PRESIDENT
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

DIAMONDVIEW
IDPH LICENSE NUMBER 0038638

TAX INDEX NUMBER	PROPERTY DESCRIPTION	TOTAL TAX	APPLICABLE TAX
14-00-080-550	COUNTRY CLUB ROAD SUB LOT 11	$36.12	$36.12
14-00-080-555	COUNTRY CLUB ROAD SUB LOT 12	$41.04	$41.04
14-00-080-565	COUNTRY CLUB ROAD SUB LOT 14	$30.38	$30.38
14-00-080-570	COUNTRY CLUB ROAD SUB LOT 15	$30.38	$30.38
14-00-080-575	COUNTRY CLUB ROAD SUB LOT 16	$30.38	$30.38

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

SALARY ALLOCATION
DIAMONDVIEW
YEAR ENDING 6/30/10

		SALARIES PER GL	%	TOTAL HOURS	VACATION HRS, ETC
HOUSEKEEPING	0.00	$0.00	0.00%	0.00	0.00
DIRECT CARE	8.82	$210,030.61	96.92%	23812.68	314.55
ACTIVITY	7.68	$6,666.06	3.08%	868.50	32.43
SOCIAL SERVICE	0.00	$0.00	0.00%	0.00	0.00
CLERICAL	0.00	$0.00	0.00%	0.00	0.00
	$8.78	$216,696.67	100.00%	24681.18	346.98

	ALLOC HRS DAY	COST REPORT	%	TOTAL HOURS	TOTAL HOURS WORKED
HOUSEKEEPING	6.00	$13,696.54	6.32%	1560.00	1538.07
ACTIVITY	6.00	$13,696.54	6.32%	1560.00	1538.07
LAUNDRY	4.00	$9,131.03	4.21%	1040.00	1025.38
COOK HELPER	2.00	$4,565.51	2.11%	520.00	512.69
DIRECT CARE		$175,607.05	81.04%	20001.18	19719.99
		$216,696.67	100.00%	24681.18	24334.20