

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0027342

Facility Name: CANTERBURY MANOR NURSING CENTER

Address: 718 NORTH MARKET STREET WATERLOO 62298
 Number City Zip Code

County: MONROE

Telephone Number: (618) 939-3650 **Fax #** (618) 939-9488

HFS ID Number: 371119687001

Date of Initial License for Current Owners: 03/01/70

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618) 549-8331
Jamestown Management Corp

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>ROGER W. BAGLEY</u>	
	(Title) <u>CONTROLLER</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,710</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</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		Total
8	SNF	<u>755</u>		<u>883</u>	<u>1,638</u>	8
9	SNF/PED					9
10	ICF	<u>12,132</u>	<u>6,760</u>		<u>18,892</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,887</u>	<u>6,760</u>	<u>883</u>	<u>20,530</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.01%

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

NONE (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 03/01/70

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 20 and days of care provided 883Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: _____

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTE # 0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	121,446	7,136	4,969	133,551		133,551		133,551		1
2	Food Purchase		71,082		71,082	2,941	74,023	(234)	73,789		2
3	Housekeeping	58,448	9,753		68,201	54	68,255		68,255		3
4	Laundry	45,181	6,488		51,669		51,669		51,669		4
5	Heat and Other Utilities			71,272	71,272	589	71,861		71,861		5
6	Maintenance	21,361	29,688	16,948	67,997		67,997	631	68,628		6
7	Other (specify):*										7
8	TOTAL General Services	246,436	124,147	93,189	463,772	3,584	467,356	397	467,753		8
	B. Health Care and Programs										
9	Medical Director			2,700	2,700		2,700		2,700		9
10	Nursing and Medical Records	807,477	25,636	47,977	881,090	(926)	880,164		880,164		10
10a	Therapy			1,944	1,944		1,944		1,944		10a
11	Activities	22,310	4,163	1,845	28,318	(1,589)	26,729		26,729		11
12	Social Services	24,736		1,845	26,581		26,581		26,581		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	854,523	29,799	56,311	940,633	(2,515)	938,118		938,118		16
	C. General Administration										
17	Administrative	53,750			53,750	61,045	114,795		114,795		17
18	Directors Fees										18
19	Professional Services			202,195	202,195	(108,860)	93,335	(88,171)	5,164		19
20	Dues, Fees, Subscriptions & Promotions			10,420	10,420	211	10,631	(3,116)	7,515		20
21	Clerical & General Office Expenses	26,315	5,703	5,613	37,631	19,401	57,032	(355)	56,677		21
22	Employee Benefits & Payroll Taxes			151,710	151,710	11,833	163,543		163,543		22
23	Inservice Training & Education			124	124		124		124		23
24	Travel and Seminar			2,155	2,155	23	2,178		2,178		24
25	Other Admin. Staff Transportation					2,915	2,915		2,915		25
26	Insurance-Prop.Liab.Malpractice			37,353	37,353	2,241	39,594		39,594		26
27	Other (specify):*										27
28	TOTAL General Administration	80,065	5,703	409,570	495,338	(11,191)	484,147	(91,642)	392,505		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,181,024	159,649	559,070	1,899,743	(10,122)	1,889,621	(91,245)	1,798,376		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 CANTERBURY MANOR NURSING CENTER #0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			20,886	20,886	2,474	23,360	38,542	61,902		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,636	1,636		1,636	(1,636)			32
33	Real Estate Taxes					1,470	1,470	24,985	26,455		33
34	Rent-Facility & Grounds			174,000	174,000	6,178	180,178	(174,000)	6,178		34
35	Rent-Equipment & Vehicles			171	171		171		171		35
36	Other (specify):*										36
37	TOTAL Ownership			196,693	196,693	10,122	206,815	(112,109)	94,706		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		48,126	78,847	126,973		126,973		126,973		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,515	40,515		40,515		40,515		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		48,126	119,362	167,488		167,488		167,488		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,181,024	207,775	875,125	2,263,924		2,263,924	(203,354)	2,060,570		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 CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	15,926	30		9
10	Interest and Other Investment Income	(41,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	2		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	(3)	21		18
19	Entertainment				19
20	Contributions	(352)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(459)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,626)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(490)	20		28
29	Other-Attach Schedule	631			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,833)		\$	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)	(174,521)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,521)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (203,354)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 CANTERBURY MANOR NURSING CENTER

ID# 0027342

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	ADJUST DEFERRED MAINT EXPENSE	\$ 631	6 1
2	PER SCHEDULE XIX		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	631	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(234)	0	0	0	0	0	0	0	0	0	0	(234)	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	631	0	0	0	0	0	0	0	0	0	0	631	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	397	0	0	0	0	0	0	0	0	0	0	397	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	(459)	(87,712)	0	0	0	0	0	0	0	0	0	(88,171)	19
20	Fees, Subscriptions & Promotions	(3,116)	0	0	0	0	0	0	0	0	0	0	(3,116)	20
21	Clerical & General Office Expenses	(355)	0	0	0	0	0	0	0	0	0	0	(355)	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	(3,930)	(87,712)	0	(91,642)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,533)	(87,712)	0	(91,245)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2007 Ending:12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	15,926	22,616	0	0	0	0	0	0	0	0	0	38,542	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(41,226)	39,590	0	0	0	0	0	0	0	0	0	(1,636)	32
33	Real Estate Taxes	0	24,985	0	0	0	0	0	0	0	0	0	24,985	33
34	Rent-Facility & Grounds	0	(174,000)	0	0	0	0	0	0	0	0	0	(174,000)	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	(25,300)	(86,809)	0	(112,109)	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)	(28,833)	(174,521)	0	(203,354)	45								

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
<u>LIST ATTACHED</u>		<u>FAIR ACRES NURSING HOME</u>	<u>DUQUOIN</u>	<u>Jamestown Mgmt</u>	<u>Carbondale</u>	<u>Management</u>
		<u>FAIRVIEW NURSING CENTER</u>	<u>DUQUOIN</u>	<u>Corp</u>		

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 <u>MANAGEMENT FEES</u>	\$ <u>196,744</u>	<u>JAMESTOWN MANAGEMENT CORPORATION</u>	<u>10.00%</u>	\$ <u>109,032</u>	\$ <u>(87,712)</u>	1
2	V	33 <u>REAL ESTATE TAXES</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>24,985</u>	<u>24,985</u>	2
3	V	34 <u>RENT</u>	<u>174,000</u>	<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>		<u>(174,000)</u>	3
4	V	32 <u>INTEREST EXPENSE</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>40,977</u>	<u>40,977</u>	4
5	V	30 <u>DEPRECIATION</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>22,616</u>	<u>22,616</u>	5
6	V	32 <u>INTEREST INCOME</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>(1,387)</u>	<u>(1,387)</u>	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>370,744</u>			\$ <u>196,223</u>	\$ * <u>(174,521)</u>	14

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO THE COST REPORT.***								\$		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 CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 JAMESTOWN MANAGEMENT CORPORATIO
 Street Address 1001 E. MAIN BLDG 4A
 City / State / Zip Code CARBONDALE, IL 62901
 Phone Number (618) 549-8331
 Fax Number (618) 549-0133

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	3	HOUSEKEEPING	HOURS OF SERVICE	12,896	\$ 6,150	\$	3,018	\$ 1,439	1
2	5	UTILITIES	HOURS OF SERVICE	12,896	2,515		3,018	589	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	9,152	260,824	260,824	2,142	61,045	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	12,896	735		3,018	172	4
5	20	LICENSES & DUES	HOURS OF SERVICE	12,896	900		3,018	211	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	3,744	66,764	66,764	876	15,621	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	12,896	12,054		3,018	2,821	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	12,896	50,562		3,018	11,833	8
9	24	SEMINARS	HOURS OF SERVICE	9,152	99		2,142	23	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	9,152	12,455		2,142	2,915	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	12,896	9,574		3,018	2,241	11
12	30	DEPRECIATION	HOURS OF SERVICE	12,896	10,572		3,018	2,474	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	12,896	6,281		3,018	1,470	13
14	34	RENT	HOURS OF SERVICE	12,896	26,400		3,018	6,178	14
15									15
16									16
17									17
18									18
19									19
20		***Excess salary of related individual has been eliminated prior to cost report.							20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 465,885	\$ 327,588		\$ 109,032	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	Canterbury Manor Nursing Center	x		1st mortgage	\$4,741.00	7/20/00	\$ 565,000	\$ 410,559	7/20/05	0.0900	\$ 40,977	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	1st National of Waterloo		x	Line of credit							1,636	6								
7												7								
8												8								
9	TOTAL Facility Related				\$4,741.00		\$ 565,000	\$ 410,559			\$ 42,613	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 565,000	\$ 410,559			\$ 42,613	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CANTERBURY MANOR NURSING CENTER COUNTY MONROE

FACILITY IDPH LICENSE NUMBER 0027342

CONTACT PERSON REGARDING THIS REPORT ROGER W. BAGLEY

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>07-24-250-031-000</u>	<u>N. Market Street part lot 1 sur 640</u>	\$ <u>1,889.00</u>	\$ <u>1,889.00</u>
2. <u>07-24-250-026-000</u>	<u>718 N. Market Street Tax lot 6 BA</u>	\$ <u>23,096.00</u>	\$ <u>23,096.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,985.00</u>	\$ <u>24,985.00</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? YES X 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 CANTERBURY MANOR NURSING CENTER

0027342 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,374 B. General Construction Type: Exterior masonry Frame _____ 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>Original bldg & addition</u>	<u>50,000</u>	<u>1970-75</u>	<u>\$ 25,823</u>	1
2	<u>Additional land</u>	<u>22,597</u>	<u>1995</u>	<u>108,977</u>	2
3	TOTALS	<u>72,597</u>		<u>\$ 134,800</u>	3

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	60		1970	1970	\$ 123,000	\$	30	\$	\$	\$ 123,000	4
5	14		1976	1976	80,226		25			80,226	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
Improvement Type**											
9		VARIOUS/FULLY DEPRECIATED		1970	14,327		VARIOUS			14,327	9
10		REMODELING		1974	565		25			565	10
11		NURSES CALL SYSTEM		1976	7,457		15			7,457	11
12		NURSES STATION		1976	30,851		20			30,851	12
13		SPRINKLER & SMOKE DETECTOR		1976	34,295		25			34,295	13
14		REMODELING		1977	6,714		15-20			6,714	14
15		LAND IMPROVEMENTS		1980	900		15			900	15
16		LAND & GUTTERING		1981	7,199		15			7,199	16
17		ROOF REPAIR & ACTIVITY ROOM		1986	30,422		15			30,422	17
18		PARKING LOT		1987	1,670		7			1,670	18
19		GAS LINE		1989	1,637		15			1,637	19
20		VARIOUS IMPROVEMENTS		1990	13,962		15			13,962	20
21		CABINETS & FLOORING		1994	2,461	164	15	164		2,215	21
22		VARIOUS IMPROVEMENTS		1994	21,632	1,442	15	1,442		19,467	22
23		ROOF REPAIR		1995	2,565	171	15	171		2,138	23
24		WATER HEATER		1995	3,000		15	200	200	2,500	24
25		FIRE ALARM		1995	7,207		15	480	480	6,000	25
26		CARPETING		1996	2,423		7			2,423	26
27		RENOVATING ROOMS		1996	4,403		10			4,403	27
28		REPLACED WATER HEATER		1996	550		15	37	37	425	28
29		REPAIR SHOWER		1996	2,244		10			2,244	29
30		LANDSCAPING		1996	973		10			973	30
31		REPLACE WATER HEATER		1996	680		15	45	45	518	31
32		Labor/materials to remove existing and install new waterproof wallcovering and floor tile		1996	4,009	167	10	200	33	4,009	32
33											33
34		Labor/materials to remove and install new cabinets/countertops in nursing station		1996	6,853	286	10	345	59	6,853	34
35											35
36		REPAIR PLUMBING		1997	4,010	267	15	267		2,804	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 CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	REPAIR GROUNDWATER DRAIN	1997	\$ 790	\$ 53	15	\$ 53	\$	\$ 556	37
38	PREP & SEAL PARKING LOT	1997	1,145		5			1,145	38
39	SIGN	1997	531		5			531	39
40	OVERBED LIGHTING	1998	8,636	864	15	576	(288)	5,472	40
41	FLOORTILE AND CARPETING	1998	10,612		15	707	707	6,717	41
42	LANDSCAPING	1998	4,817	482	10	482		4,579	42
43	Labor/materials to remove entry way, rebuild wall, paint	1998	11,907	1,191	15	794	(397)	7,543	43
44	& replace elec serv in DON, socserv, breakroom. Move wall								44
45	to expand kitchen. Created storage area by relocating doors.								45
46	Trim, pictures, mirrors & other permanent fixtures to	1998	3,025	49	5		(49)	3,025	46
47	refurbish the remodeled building.								47
48	PARKING LOT	1998	56,963		15	3,798	3,798	36,081	48
49	WATER SOFTNER	1998	1,400		10	140	140	1,330	49
50	FIRE SUPPRESSION SYSTEM	1998	1,356		10	136	136	1,292	50
51	GAZEBO	1999	4,084		20	204	204	1,734	51
52	COURTYARD AWNINGS	1999	850		5			850	52
53	INSTALL 911 ALARM SYSTEM	1999	519		5			519	53
54	LANDSCAPING AND SIDEWALKS	1999	2,189	219	10	219		1,861	54
55	WINDOWS FOR FRONT OF BUILDING	1999	2,658	266	10	266		2,261	55
56	LANDSCAPING OF COURTYARD	1999	466	47	10	47		399	56
57	WALLPAPERING	1999	218		5			218	57
58	BUILDING ADDITION	1999	411,559		15	27,437	27,437	205,778	58
59	ADJUSTMENT TO 1999 DPA COST REPORT	1999	(173)						59
60	BUILDING ADDITION	199	17,651		15	1,177	1,177	8,827	60
61	DOOR ALARM SYSTEM	2000	5,996		10	600	600	4,500	61
62	Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10	135	135	1,012	62
63	heating, electrical services, and lighting in the breakroom								63
64	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10	107	107	803	64
65	Labor/materials to remove existing wall and relocate wall	2000	9,093	596	10	909	313	6,818	65
66	to expand nures station and install new cabinetry &								66
67	countertops, lighting, and electrical services								67
68	INSTALL TILE FLOORING IN EAST WING	2000	6,858	449	15	457	8	3,428	68
69	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	379	15	386	7	2,895	69
70	TOTAL (lines 4 thru 69)		\$ 1,048,383	\$ 7,092		\$ 41,981	\$ 34,889	\$ 781,163	70

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,048,383	\$ 7,092		\$ 41,981	\$ 34,889	\$ 781,163	1
2	Labor and materials to remove existing cabinetry and sinks	2000	2,845	186	15	190	4	1,425	2
3	and install new cabinets/sinks, replace plumbing and								3
4	electrical on east wing								4
5	ABSTRACT WATER FOUNTAIN IN COURTYARD	2000	1,155	52	5		(52)	1,155	5
6	FURIT URN FOUNTAIN IN DRIVE	2000	945	44	5		(44)	945	6
7	LANDSCAPING	2000	1,519	99	10	152	53	1,140	7
8	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		1,677	8
9	Replaced employee door, new frame, door, and hardware	2001	2,129	213	10	213		1,384	9
10	Code modifications to fire sprinkler system	2001	2,566	257	10	257		1,670	10
11	Installation & replacement of aluminum patio door system	2001	4,223	422	10	422		2,743	11
12	Replace pressure switch and repair lines in fire sprinkler system	2002	5,790	579	10	579		3,185	12
13	SEAL AND STRIPE PARKING LOT	2002	3,440	344	5	344		3,440	13
14	Relocate 2 water meters to meet city code	2003	1,700	113	15	113		622	14
15	REPLACED WATER HEATER	2003	3,539	316	10	354	38	1,593	15
16	REPLACED WATER SOFTNER	2003	1,913	171	10	191	20	860	16
17	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898	334	10	290	(44)	1,305	17
18	Demolition and reconstruction of wall, relocate door, and	200	6,155	616	10	616		2,772	18
19	intall electrical service for laundry								19
20	Replace flooring in south hall bathroom	2004	2,039	204	10	204		714	20
21	Replaced fixtures and cabinets in soiled utility room. Repaired	2004	2,083	208	10	208		728	21
22	walls and doors and painted								22
23	Replace roof on south wing and northwest slope	2005	32,123		10	3,212	3,212	8,030	23
24	Install floor tile in hall, sec, conf, admin offices	2006	4,770	682	15	318	(364)	477	24
25	Repairs to sprinkler system	2006	8,113	811	10	811		1,217	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,142,203	\$ 13,001		\$ 50,713	\$ 37,712	\$ 818,245	34

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 71,029	\$ 4,347	\$ 8,257	\$ 3,910	variable	\$ 42,647	71
72	Current Year Purchases	9,130	3,538	458	(3,080)	variable	458	72
73	Fully Depreciated Assets	215,480				variable	215,480	73
74								74
75	TOTALS	\$ 295,639	\$ 7,885	\$ 8,715	\$ 830		\$ 258,585	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	JAMESTOWN ALLOCATION			\$	\$ 2,474	\$ 2,474	\$		\$ 32,799	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 2,474	\$ 2,474	\$		\$ 32,799	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,572,642	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,360	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,902	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,542	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,109,629	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.

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 171 Description: Storage 171

(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.

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 type="checkbox"/> YES <input checked="" 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><u>We only hire trained aides.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	39/3;39/2	hrs	\$	411	\$ 31,949	\$ 38	411	\$ 31,987	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		43	3,665	13	43	3,678	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		485	37,935	250	485	38,185	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				25,581		25,581	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, med sup Other (specify): lab, xray	39/2 39/3				5,298	22,244		27,542	13
14	TOTAL			\$	939	\$ 78,847	\$ 48,126	939	\$ 126,973	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 CANTERBURY MANOR NURSING CENTER# 0027342Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(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	\$ 53,070	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	338,206		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	216,321		5
6	Prepaid Insurance	7,703		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Fed Tax Deposit</u>	7,500		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 622,800	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	236,959		15
16	Equipment, at Historical Cost	228,288		16
17	Accumulated Depreciation (book methods)	(412,029)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan to Waterloo Land Trust</u>	410,559		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 463,777	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,086,577	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 37,947	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,843		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,674		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>401K Liability</u>	9,294		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 105,758	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 105,758	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 980,819	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,086,577	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 771,294	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 771,294	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	209,525	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)	\$ 209,525	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)	\$ 980,819	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 2,201,372	1
2	Discounts and Allowances for all Levels	51,909	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,253,281	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,640	6
7	Oxygen	24,424	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 151,064	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,942	19
20	Radiology and X-Ray	1,375	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,317	23
D. Non-Operating Revenue			
24	Contributions	17,550	24
25	Interest and Other Investment Income***	47,237	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,787	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,473,449	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	463,772	31
32	Health Care	940,633	32
33	General Administration	495,338	33
B. Capital Expense			
34	Ownership	196,693	34
C. Ancillary Expense			
35	Special Cost Centers	126,973	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,263,924	40
41	Income before Income Taxes (line 30 minus line 40)**	209,525	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 209,525	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation. IL taxes are deducted c

*** 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 CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,936	2,080	\$ 50,286	\$ 24.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,050	2,299	45,501	19.79	3
4	Licensed Practical Nurses	14,602	15,781	288,043	18.25	4
5	CNAs & Orderlies	35,519	37,582	414,527	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	2,123	22,310	10.51	9
10	Activity Assistants					10
11	Social Service Workers	1,889	2,035	24,736	12.16	11
12	Dietician					12
13	Food Service Supervisor	1,869	2,061	32,326	15.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,790	9,383	89,120	9.50	15
16	Dishwashers					16
17	Maintenance Workers	1,579	1,826	21,361	11.70	17
18	Housekeepers	6,380	6,796	58,448	8.60	18
19	Laundry	4,432	4,732	45,181	9.55	19
20	Administrator	1,680	1,796	53,750	29.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,991	2,147	26,315	12.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>ward clerk</u>	917	1,011	9,120	9.02	33
34	TOTAL (lines 1 - 33)	85,620	91,652	\$ 1,181,024 *	\$ 12.89	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	96	\$ 4,969	1/3	35
36	Medical Director		2,700	9/3	36
37	Medical Records Consultant	24	1,104	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10/3	39
40	Physical Therapy Consultant	31	1,944	10A/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,845	11/3	44
45	Social Service Consultant	27	1,845	12/3	45
46	Other(specify)				46
47	<u>Billing Consultant</u>		3,796	19/3	47
48	<u>Purchasing Consultant</u>		11	19/3	48
49	TOTAL (lines 35 - 48)	205	\$ 18,814		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	L10/C3	50
51	Licensed Practical Nurses	534	16,642	L10/C3	51
52	Certified Nurse Assistants/Aides	1,499	29,531	L10/C3	52
53	TOTAL (lines 50 - 52)	2,033	\$ 46,173		53

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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	PAINTING	2005	\$ 1,894		\$	316	631	631	316				
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,894		\$	316	631	631	316				

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

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? NO
If YES, give association name and amount. _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 40,515
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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? NONE
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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.

CANTERBURY MANOR NURSING CENTER #0023742

RECLASSIFICATION ON DPA COST REPORT
 PAGES 3 & 4 COLUMN 5

12/31/2007

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	1352	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		1352
21	CLERICAL & GEN OFFICE EXPENSE	959	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		959
10	NURISNG & MEDICAL RECORDS	1385	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		1385
2	FOOD PURCHASES	1589	
11	ACTIVITIES RECLASSIFY FOOD USED IN ACTIVITIES		1589
VARIOUS	VARIOUS LINE ITEMS	109032	
19	PROFESSIONAL SERVICES RECLASSIFY JAMESTOWN ALLOCATION SEE SCHEDULE VIII FOR BREAKDOWN		109032