

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	2,017	1,256	1,200	4,473	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	9,465	5,283		14,748	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	11,482	6,539	1,200	19,221	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.16%

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)
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

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 1,200

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: _____

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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					9	10
	A. General Services	1	2	3	4	5	6	7	8	9	10
1	Dietary	113,170	9,307	5,342	127,819		127,819		127,819		1
2	Food Purchase		81,140		81,140	4,158	85,298	(280)	85,018		2
3	Housekeeping	57,682	12,866		70,548	(53)	70,495		70,495		3
4	Laundry	40,961	6,790		47,751		47,751		47,751		4
5	Heat and Other Utilities			75,534	75,534	674	76,208		76,208		5
6	Maintenance	27,348	23,745	45,485	96,578		96,578		96,578		6
7	Other (specify):*										7
8	TOTAL General Services	239,161	133,848	126,361	499,370	4,779	504,149	(280)	503,869		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	915,685	40,171	107,272	1,063,128	(2,800)	1,060,328		1,060,328		10
10a	Therapy			3,786	3,786		3,786		3,786		10a
11	Activities	23,662	4,596	1,795	30,053	(1,475)	28,578		28,578		11
12	Social Services	30,867		1,795	32,662		32,662		32,662		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	970,214	44,767	117,048	1,132,029	(4,275)	1,127,754		1,127,754		16
	C. General Administration										
17	Administrative	62,385			62,385	52,320	114,705		114,705		17
18	Directors Fees										18
19	Professional Services			197,575	197,575	(102,785)	94,790	(91,483)	3,307		19
20	Dues, Fees, Subscriptions & Promotions			8,383	8,383	201	8,584	(3,577)	5,007		20
21	Clerical & General Office Expenses	25,928	8,506	5,666	40,100	24,455	64,555	(265)	64,290		21
22	Employee Benefits & Payroll Taxes			171,402	171,402	11,228	182,630		182,630		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,619	3,619	683	4,302		4,302		24
25	Other Admin. Staff Transportation					2,378	2,378		2,378		25
26	Insurance-Prop.Liab.Malpractice			32,397	32,397	1,957	34,354		34,354		26
27	Other (specify):*										27
28	TOTAL General Administration	88,313	8,506	419,042	515,861	(9,563)	506,298	(95,325)	410,973		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,297,688	187,121	662,451	2,147,260	(9,059)	2,138,201	(95,605)	2,042,596		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: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,528	15,528	1,761	17,289	45,507	62,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					1,438	1,438	23,986	25,424			33
34	Rent-Facility & Grounds			174,000	174,000	5,860	179,860	(174,000)	5,860			34
35	Rent-Equipment & Vehicles			11,979	11,979		11,979		11,979			35
36	Other (specify):*											36
37	TOTAL Ownership			201,507	201,507	9,059	210,566	(104,507)	106,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,990	101,454	167,444		167,444		167,444			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		65,990	141,969	207,959		207,959		207,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,297,688	253,111	1,005,927	2,556,726		2,556,726	(200,112)	2,356,614			45

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

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	22,891	30		9
10	Interest and Other Investment Income	(23,575)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(280)	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	(15)	21		18
19	Entertainment				19
20	Contributions	(250)	21		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	(2,737)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(840)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,806)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (195,306)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (200,112)		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					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: 01/01/2009

Ending: 12/31/2009

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 CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(280)	0	0	0	0	0	0	0	0	0	0	(280)	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	(280)	0	0	0	0	0	0	0	0	0	0	(280)	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	(91,483)	0	0	0	0	0	0	0	0	0	(91,483)	19
20	Fees, Subscriptions & Promotions	(3,577)	0	0	0	0	0	0	0	0	0	0	(3,577)	20
21	Clerical & General Office Expenses	(265)	0	0	0	0	0	0	0	0	0	0	(265)	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	(3,842)	(91,483)	0	(95,325)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,122)	(91,483)	0	(95,605)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	22,891	22,616	0	0	0	0	0	0	0	0	0	45,507	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,575)	23,575	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	23,986	0	0	0	0	0	0	0	0	0	23,986	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	(684)	(103,823)	0	(104,507)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(4,806)	(195,306)	0	0	0	0	0	0	0	0	0	(200,112)	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	<u>19</u>	<u>MANAGEMENT FEES</u>	\$ <u>194,483</u>	<u>JAMESTOWN MANAGEMENT CORPORATION</u>	<u>10.00%</u>	\$ <u>103,000</u>	\$ <u>(91,483)</u>	1
2	V	<u>33</u>	<u>REAL ESTATE TAXES</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>23,986</u>	<u>23,986</u>	2
3	V	<u>34</u>	<u>RENT</u>	<u>174,000</u>	<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>		<u>(174,000)</u>	3
4	V	<u>32</u>	<u>INTEREST EXPENSE</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>23,621</u>	<u>23,621</u>	4
5	V	<u>30</u>	<u>DEPRECIATION</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>22,616</u>	<u>22,616</u>	5
6	V	<u>32</u>	<u>INTEREST INCOME</u>		<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>(46)</u>	<u>(46)</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>368,483</u>				\$ <u>173,177</u>	\$ * <u>(195,306)</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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

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

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization JAMESTOWN MANAGEMENT CORPORATIO
 Street Address 1001 E. MAIN BLDG 4A
 City / State / Zip Code CARBONDALE, IL 69201
 Phone Number (618) 549-8331
 Fax Number (618) 549-0133

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	13,172	\$ 5,881	\$	2,924	\$ 1,305	1	
2	5	UTILITIES	HOURS OF SERVICE	13,172	3,035		2,924	674	2	
3	17	ADMINSTRATIVE	HOURS OF SERVICE	8,320	235,680	235,680	1,847	52,320	3	
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,172	970		2,924	215	4	
5	20	LICENSES & DUES	HOURS OF SERVICE	13,172	907		2,924	201	5	
6	21	CLERICAL SALARIES	HOURS OF SERVICE	4,852	90,374	90,374	1,077	20,060	6	
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	13,172	13,154		2,924	2,920	7	
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,172	50,581		2,924	11,228	8	
9	24	SEMINARS	HOURS OF SERVICE	8,320	3,075		1,847	683	9	
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320	10,714		1,847	2,378	10	
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,172	8,816		2,924	1,957	11	
12	30	DEPRECIATION	HOURS OF SERVICE	13,172	7,935		2,924	1,761	12	
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,172	6,480		2,924	1,438	13	
14	34	RENT	HOURS OF SERVICE	13,172	26,400		2,924	5,860	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21		***Excess salary of related individual has been eliminated prior to the cost report.***								21
22									22	
23									23	
24									24	
25	TOTALS				\$ 464,002	\$ 326,054		\$ 103,000	25	

Facility Name & ID Number CANTERBURY MANOR NURSING CENTE

0027342

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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	X		1ST MORTGAGE	\$7,741.00	12/20/07	\$ 410,559	\$ 276,997	04/20/2013	0.0750	\$ 23,621	1							
2	NURSING CENTER											2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$7,741.00		\$ 410,559	\$ 276,997			\$ 23,621	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 410,559	\$ 276,997			\$ 23,621	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 CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Original bldg & addition</u>	<u>50,000</u>	<u>1970-75</u>	<u>\$ 25,823</u>	<u>1</u>
2	<u>Additional land</u>	<u>22,597</u>	<u>1995</u>	<u>108,977</u>	<u>2</u>
3	TOTALS	<u>72,597</u>		<u>\$ 134,800</u>	<u>3</u>

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		10			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 IMPROVEMENT		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	49	15	82	33	2,461	21
22		VARIOUS IMPROVEMENTS		1994	21,632	723	15	723		21,632	22
23		ROOF REPAIR		1995	2,565	171	15	171		2,480	23
24		WATER HEATER		1995	3,000		15	200	200	2,900	24
25		FIRE ALARM		1995	7,207		15	480	480	6,960	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	499	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	608	31
32		Labor/materials to remove existing and install new waterproof wallcovering and floor tile		1996	4,009		10			4,009	32
33											33
34		Labor/materials to remoe and install new cabinets/countertops in nursing station		1996	6,853		10			6,853	34
35											35
36		REPAIR PLUMBING		1997	4,010	267	15	267		3,338	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:

01/01/2009 Ending: 12/31/2009

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		\$ 662	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		15	576	576	6,624	40
41	FLOORTILE AND CARPETING	1998	10,612		15	707	707	8,131	41
42	LANDSCAPING	1998	4,817		10			4,817	42
43	Labor/materials to remove entry way, rebuild wall, paint	1998	11,907		15	794	794	9,131	43
44	& replace elec serv in DON, socservk 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		5			3,025	46
47	refurbish the remodeled building.								47
48	PARKING LOT	1998	56,963		15	3,798	3,798	43,677	48
49	WATER SOFTNER	1998	1,400		10			1,400	49
50	FIRE SUPPRESION SYSTEM	1998	1,356		10			1,356	50
51	GAZEBO	1999	4,084		20	204	204	2,142	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	54	10	109	55	2,189	54
55	WINDOWS FOR FRONT OF BUILDING	1999	2,658	131	10	131		2,658	55
56	LANDSCAPING OF COURTYARD	1999	466	35	10	20	(15)	466	56
57	WALLPAPERING	1999	218		5			218	57
58	BUILDING ADDITION	1999	411,559		15	27,437	27,437	260,652	58
59	ADJUSTMENT TO 1999 DPA COST REPORT	1999	(173)						59
60	BUILDING ADDITION	1999	17,651		15	1,177	1,177	11,181	60
61	DOOR ALARM SYSTEM	2000	5,996		10	600	600	5,700	61
62	Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10	135	135	1,282	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	1,017	64
65	Labor/materials to remove existing wall and relocate wall	2000	9,093	596	10	909	313	8,636	65
66	to expand nurses station and install new cabinety &								66
67	countertops, lighting and electrical services								67
68	INSTALL TILE FLOORING IN EAST WING	2000	6,858	449	15	457	8	4,342	68
69	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	379	15	386	7	3,667	69
70	TOTAL (lines 4 thru 69)		\$ 1,048,383	\$ 2,907		\$ 39,605	\$ 36,698	\$ 861,818	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:

01/01/2009 Ending: 12/31/2009

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	\$ 2,907		\$ 39,605	\$ 36,698	\$ 861,818	1
2	Labor and materials to remove existing cabinety and sinks	2000	2,845	186	15	190	4	1,805	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		5			1,155	5
6	FRUIT URN FOUNTAIN IN DRIVE	2000	945		5			945	6
7	LADNSCAPING	2000	1,519	99	10	152	53	1,444	7
8	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		2,193	8
9	Replaced employee door, new frame, door and hardware	2001	2,129	213	10	213		1,810	9
10	Code modifications to fire sprinkler system	2001	2,566	257	10	257		2,184	10
11	Installation & replacement of aluminum patio door system	2001	4,223	422	10	422		3,587	11
12	Replace pressure switch and repair lines in fire sprinkler sys	2002	5,790	579	10	579		4,343	12
13	SEAL AND STRIPE PARKING LOT	2002	3,440		5			3,440	13
14	Relocate 2 water meters to meet city code	2003	1,700	113	15	113		848	14
15	REPLACED WATER HEATER	2003	3,539	316	10	354	38	2,301	15
16	REPLACED WATER SOFTNER	2003	1,913	171	10	191	20	1,242	16
17	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898		10	290	290	1,885	17
18	Demolition and reconstruction of wall, relocate door and	2003	6,155	616	10	616		4,004	18
19	install electrical service for laundry								19
20	Replace flooring in south hall bathroom	2004	2,039	204	10	204		1,122	20
21	Replaced fixtures and cabinets in soiled utility room	2004	2,083	208	10	208		1,144	21
22	Repaired wall and doors and painted.				10				22
23	Replace roof on south wing and northwest slope	2005	32,123		15	3,212	3,212	14,454	23
24	Install floor tile in hall, sec, conf, admin offices	2006	4,770	681	10	318	(363)	1,113	24
25	Repairs to sprinkler system	2006	8,113	811	15	811		2,839	25
26	Install floor tile in small dining room	2008	2,575	172	5	172	172	258	26
27	Repair asphalt, fill, seal and stripe parking lot	2008	5,100	729	10	1,020	291	1,530	27
28	Replace roof on north wing	2008	20,131			2,013	2,013	3,020	28
29	INSTALL FIRE DOOR & FRAMES	2009	2,950	37		148	111	148	29
30	REPLACE COMPRESSOR IN SPRINKLER SYSTEM	2009	5,180	43		259	216	259	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,178,139	\$ 8,850		\$ 51,605	\$ 42,755	\$ 920,891	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 68,187	\$ 4,809	\$ 8,697	\$ 3,888	VARIABLE	\$ 45,702	71
72	Current Year Purchases	15,148	1,869	733	(1,136)	VARIABLE	733	72
73	Fully Depreciated Assets	231,775				VARIABLE	231,775	73
74								74
75	TOTALS	\$ 315,110	\$ 6,678	\$ 9,430	\$ 2,752		\$ 278,210	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			\$	\$ 1,761	\$ 1,761	\$		\$ 37,275	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,761	\$ 1,761	\$		\$ 37,275	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)	\$ 1,628,049	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,289	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,796	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,507	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,236,376	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

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: \$ 11,979 Description: SEE BREAKDOWN ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$	455	\$ 35,481	\$ 38	455	\$ 35,519	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		148	12,417		148	12,417	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		593	44,866	248	593	45,114	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 prescripts				39,178		39,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	oxygen, tubefeed, med sup Other (specify): <u>lab, xray</u>	39/2 39/3				8,690	26,526		35,216	13
14	TOTAL			\$	1,196	\$ 101,454	\$ 65,990	1,196	\$ 167,444	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**

0027342

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (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	\$ 41,454	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,990		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	308,940		5
6	Prepaid Insurance	8,219		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	13,200		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 674,803	\$	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	252,763		15
16	Equipment, at Historical Cost	247,759		16
17	Accumulated Depreciation (book methods)	(450,640)		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>	276,997		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 326,879	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,001,682	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 49,176	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,711		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,402		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>	8,423		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 98,712	\$	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)	\$ 98,712	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 902,970	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,001,682	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,029,622	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,029,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,950)	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) 2008 Corporate Income Taxes	(12,702)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (126,652)	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)	\$ 902,970	24 *

* This must agree with page 17, line 47.

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	\$ 2,123,434	1
2	Discounts and Allowances for all Levels	60,373	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,183,807	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,800	6
7	Oxygen	33,798	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 212,598	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	2,002	19
20	Radiology and X-Ray	3,194	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,196	23
D. Non-Operating Revenue			
24	Contributions	17,115	24
25	Interest and Other Investment Income***	24,060	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,175	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)	\$ 2,442,776	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	499,370	31
32	Health Care	1,132,029	32
33	General Administration	515,861	33
B. Capital Expense			
34	Ownership	201,507	34
C. Ancillary Expense			
35	Special Cost Centers	167,444	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)*	\$ 2,556,726	40
41	Income before Income Taxes (line 30 minus line 40)**	(113,950)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (113,950)	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 Federal tax return

*** 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: 01/01/2009

Ending: 12/31/2009

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	1,976	2,080	\$ 54,348	\$ 26.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,671	1,713	40,258	23.50	3
4	Licensed Practical Nurses	15,384	16,926	324,889	19.19	4
5	CNAs & Orderlies	40,092	42,412	485,386	11.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,972	2,106	23,662	11.24	9
10	Activity Assistants					10
11	Social Service Workers	1,939	1,996	30,867	15.46	11
12	Dietician					12
13	Food Service Supervisor	1,950	2,052	20,516	10.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,534	10,018	92,654	9.25	15
16	Dishwashers					16
17	Maintenance Workers	2,018	2,143	27,348	12.76	17
18	Housekeepers	6,313	6,613	57,682	8.72	18
19	Laundry	4,418	4,696	40,961	8.72	19
20	Administrator	2,032	2,080	62,385	29.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,102	2,182	25,928	11.88	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>	1,246	1,311	10,804	8.24	33
34	TOTAL (lines 1 - 33)	92,647	98,328	\$ 1,297,688 *	\$ 13.20	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	\$ 5,342	1/3	35
36	Medical Director		2,400	9/3	36
37	Medical Records Consultant	24	1,104	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		604	10/3	39
40	Physical Therapy Consultant	52	3,236	10a/3	40
41	Occupational Therapy Consultant	6	416		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	134		43
44	Activity Consultant	26	1,795	11/3	44
45	Social Service Consultant	26	1,795	12/3	45
46	Other(specify)				46
47	<u>Purchasing consultant</u>			19/3	47
48					48
49	TOTAL (lines 35 - 48)	232	\$ 16,826		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	142	\$ 6,011	L10/C3	50
51	Licensed Practical Nurses	882	28,537	L10/C3	51
52	Certified Nurse Assistants/Aides	3,319	71,016	L10/C3	52
53	TOTAL (lines 50 - 52)	4,343	\$ 105,564		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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINTING	2005	\$ 1,984		\$ 631	\$ 631	\$ 316	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,984		\$ 631	\$ 631	\$ 316	\$	\$	\$	\$	\$	\$

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? 11 YEARS
- (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? N/A
 - 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? 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? NO
Firm Name: _____
- (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
 12/31/2009

RECLASSIFICATION ON DPA COST REPORT
 PAGES 3 & 4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	2683	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2683
21	CLERICAL & GEN OFFICE EXPENSE	1475	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		1475
10	NURSING & MEDICAL RECORDS	1358	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		1358
2	FOOD PURCHASES	1475	
11	ACTIVITIES RECLASSIFY FOOD USED IN ACTIVITIES		1475
VARIOUS	VARIOUS LINE ITEMS PROFESSIONAL SERVICES RECLASSIFY JAMESTOWN ALLOCATION SEE SCHEDULE VIII FOR BREAKDOWN	103000	103000

CANTERBURY MANOR NURSING CENTER #0023742
12/31/2009

SCHEDULE OF BREAKDOWN OF MOVABLE EQUIPMENT

STORAGE	187
RECLINER	292
BEDS AND MATTRESSES	6409
C-PAP MACHINE	742
ROHO MATTRESS	30
ROHO CUSHION	15
GERI CHAIR	3
WOUND VAC	4064
PATIENT LIFT	226
WHEEL CHAIR	<u>11</u>
TOTAL	11979