

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,980	1,193	692	3,865	8
9	SNF/PED					9
10	ICF	9,356	4,813		14,169	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,336	6,006	692	18,034	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.77%

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 692

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 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:

01/01/2010

Ending:

12/31/2010

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	114,063	7,149	5,435	126,647		126,647		126,647		1
2	Food Purchase		74,986		74,986	3,286	78,272	(262)	78,010		2
3	Housekeeping	59,300	8,596		67,896	449	68,345		68,345		3
4	Laundry	39,983	5,802		45,785		45,785		45,785		4
5	Heat and Other Utilities			76,305	76,305	668	76,973		76,973		5
6	Maintenance	28,026	14,410	45,393	87,829		87,829		87,829		6
7	Other (specify):*										7
8	TOTAL General Services	241,372	110,943	127,133	479,448	4,403	483,851	(262)	483,589		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	886,099	36,812	47,146	970,057	(1,788)	968,269		968,269		10
10a	Therapy			2,479	2,479		2,479		2,479		10a
11	Activities	23,983	2,871	1,708	28,562	(1,226)	27,336		27,336		11
12	Social Services	33,617		1,708	35,325		35,325		35,325		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	943,699	39,683	55,441	1,038,823	(3,014)	1,035,809		1,035,809		16
	C. General Administration										
17	Administrative	53,285			53,285	47,828	101,113		101,113		17
18	Directors Fees										18
19	Professional Services			182,602	182,602	(95,275)	87,327	(82,984)	4,343		19
20	Dues, Fees, Subscriptions & Promotions			12,281	12,281	151	12,432	(6,043)	6,389		20
21	Clerical & General Office Expenses	27,192	8,327	5,592	41,111	23,475	64,586	(4)	64,582		21
22	Employee Benefits & Payroll Taxes			176,829	176,829	10,378	187,207		187,207		22
23	Inservice Training & Education			351	351		351		351		23
24	Travel and Seminar			2,525	2,525	167	2,692		2,692		24
25	Other Admin. Staff Transportation					1,909	1,909		1,909		25
26	Insurance-Prop.Liab.Malpractice			52,072	52,072	1,887	53,959		53,959		26
27	Other (specify):*										27
28	TOTAL General Administration	80,477	8,327	432,252	521,056	(9,480)	511,576	(89,031)	422,545		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,265,548	158,953	614,826	2,039,327	(8,091)	2,031,236	(89,293)	1,941,943		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:

01/01/2010

Ending:

12/31/2010

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			17,089	17,089	1,557	18,646	42,313	60,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					1,297	1,297	29,661	30,958			33
34	Rent-Facility & Grounds			174,000	174,000	5,237	179,237	(174,000)	5,237			34
35	Rent-Equipment & Vehicles			4,818	4,818		4,818		4,818			35
36	Other (specify):*											36
37	TOTAL Ownership			195,907	195,907	8,091	203,998	(102,026)	101,972			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,831	65,342	124,173		124,173		124,173			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		58,831	105,857	164,688		164,688		164,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,265,548	217,784	916,590	2,399,922		2,399,922	(191,319)	2,208,603			45

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

ID# 0027342

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

Sch. V Line

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

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	19,697	30		9
10	Interest and Other Investment Income	(16,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(262)	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	(4)	21		18
19	Entertainment				19
20	Contributions		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	(4,998)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,045)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,697)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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	(188,622)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (188,622)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (191,319)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(262)	0	0	0	0	0	0	0	0	0	0	(262)	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	(262)	0	0	0	0	0	0	0	0	0	0	(262)	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	(82,984)	0	0	0	0	0	0	0	0	0	(82,984)	19
20	Fees, Subscriptions & Promotions	(6,043)	0	0	0	0	0	0	0	0	0	0	(6,043)	20
21	Clerical & General Office Expenses	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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	(6,047)	(82,984)	0	(89,031)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,309)	(82,984)	0	(89,293)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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	19,697	22,616	0	0	0	0	0	0	0	0	0	42,313	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,085)	16,085	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	29,661	0	0	0	0	0	0	0	0	0	29,661	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	3,612	(105,638)	0	(102,026)	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)	(2,697)	(188,622)	0	(191,319)	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>JAMESTOWN MANAGEMENT CORPORATION</u>	<u>10.00%</u>	<u>\$ 95,493</u>	<u>\$ (82,984)</u>	1
2	V	33	<u>REAL ESTATE TAXES</u>	<u>WATERLOO LAND TRUST</u>	<u>100.00%</u>	<u>29,661</u>	<u>29,661</u>	2
3	V	34	<u>RENT</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>18,243</u>	<u>18,243</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>(2,158)</u>	<u>(2,158)</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>\$ 352,477</u>			<u>\$ 163,855</u>	<u>\$ * (188,622)</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:

01/01/2010

Ending:

12/31/2010

VII. RELATED PARTIES (continued)

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

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

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

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization JAMESTOWN MANAGEMENT CORP
 Street Address 1001 E MAIN BLDG 4A
 City / State / Zip Code CARBONDALE, IL 62901
 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	13,968	\$ 5,802	\$	2,771	\$ 1,151	1
2	5	UTILITIES	HOURS OF SERVICE	13,968	3,365		2,771	668	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	8,320	241,025	241,025	1,651	47,828	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,968	1,098		2,771	218	4
5	20	LICENSES & DUES	HOURS OF SERVICE	13,968	760		2,771	151	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,648	103,474	103,474	1,120	20,519	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	13,968	12,733		2,771	2,526	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,968	52,313		2,771	10,378	8
9	24	SEMINARS	HOURS OF SERVICE	8,320	844		1,651	167	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	8,320	9,622		1,651	1,909	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,968	9,512		2,771	1,887	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,968	7,851		2,771	1,557	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,968	6,536		2,771	1,297	13
14	34	RENT	HOURS OF SERVICE	13,968	26,400		2,771	5,237	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.***								
22									22
23									23
24									24
25	TOTALS				\$ 481,335	\$ 344,499		\$ 95,493	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										
										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	\$ 202,342	4/20/2013	0.0750	\$ 18,243	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	\$ 202,342			\$ 18,243	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	\$ 202,342			\$ 18,243	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	29,661	2
3. Under or (over) accrual (line 2 minus line 1).			\$	29,661	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	29,661	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	23,185	8
	2006	24,985	9
	2007	25,613	10
	2008	23,986	11
	2009	29,661	12

***Line 7 does not include the Jamestown allocation from page 8 SCHVIII of \$1297.

Real estate taxes on page 4 line 33 should reconcile to line 7 \$29661 + Jamestown \$1297 = \$30958.

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-24-250-031-000</u>	<u>N. Market Street part lot 1 sur 640</u>	\$ <u>1,931.90</u>	\$ <u>1,931.90</u>
2. <u>07-24-250-026-000</u>	<u>718 N. Market Street Tax lot 6 BA</u>	\$ <u>27,729.34</u>	\$ <u>27,729.34</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>29,661.24</u>	\$ <u>29,661.24</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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	Original bldg & addition	50,000	1970-75	\$ 25,823	1
2	Additional land	22,597	1995	108,977	2
3	TOTALS	72,597		\$ 134,800	3

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

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		15			2,461	21
22	VARIOUS IMPROVEMENTS		1994		21,632		15			21,632	22
23	ROOF REPAIR		1995		2,565	85	15	85		2,565	23
24	WATER HEATER		1995		3,000		15	100	100	3,000	24
25	FIRE ALARM		1995		7,207		15	247	247	7,207	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	536	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	653	31
32	Labor/materials to remove existing and install new waterproof wallcovering and floor tile.		1996		4,009		10			4,009	32
34	Labor/materials to remove and install new cabinets/countertops in nursing station		1996		6,853		10			6,853	34
35	REPAIR PLUMBING		1997		4,010	267	15	267		3,605	35

*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:

01/01/2010 Ending: 12/31/2010

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 REPAIR GROUNDWATER DRAIN	1997	\$ 790	\$ 53	15	\$ 53	\$	\$ 715	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	7,200	40
41 FLOORTILE AND CARPETING	1998	10,612		15	707	707	8,838	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	9,925	43
44 & replace elec serv in DON, soc ser,& 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	47,475	48
49 WATER SOFTENER	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	2,346	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		10			2,189	54
55 WINDOWS FOR FRONT OF BUILDING	1999	2,658		10			2,658	55
56 LANDSCAPING OF COURTYARD	1999	466		10			466	56
57 WALLPAPERING	1999	218		5			218	57
58 BUILDING ADDITION	1999	411,559		15	27,437	27,437	288,089	58
59 ADJUSTMENT TO 1999 DPA COST REPORT	1999	(173)						59
60 BUILDING ADDITION	1999	17,651		15	1,177	1,177	12,358	60
61 DOOR ALARM SYSTEM	2000	5,996		10	296	296	5,996	61
62 Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10	64	64	1,346	62
63 heating, electrical services, and lighting in the breakroom.								63
64 EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10	54	54	1,071	64
65 Labor/materials to remove existing wall and relocate wall	2000	9,093	298	10	457	159	9,093	65
66 to expand nurses station and install new cabinetry &								66
67 countertops, lighting, and electrical services.								67
68 INSTALL TILE FLOORING IN EAST WING	2000	6,858	227	15	457	230	4,799	68
69 CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	190	15	386	196	4,053	69
70 TOTAL (lines 4 thru 69)		\$ 1,048,383	\$ 1,120		\$ 37,241	\$ 36,121	\$ 899,059	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:

01/01/2010 Ending: 12/31/2010

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	10
	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	\$ 1,120		\$ 37,241	\$ 36,121	\$ 899,059	1
2	Labor and materials to remove existing cabinetry and sinks	2000	2,845	94	15	190	96	1,995	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	LANDSCAPING	2000	1,519	52	10	75	23	1,519	7
8	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		2,451	8
9	Replaced employee door, new frame, door, and hardware	2001	2,129	213	10	213		2,023	9
10	Code modification to fire sprinkler system	2001	2,566	257	10	257		2,441	10
11	Installation & replacement of aluminum patio door system	2001	4,223	422	10	422		4,009	11
12	Replace pressure switch and repair lines in fire sprinkler system	2002	5,790	579	10	579		4,922	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		961	14
15	REPLACED WATER HEATER	2003	3,539	157	10	354	197	2,655	15
16	REPLACED WATER SOFTNER	2003	1,913	85	10	191	106	1,433	16
17	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898		10	290	290	2,175	17
18	Demolition and reconstruction of wall, relocated door, and	2003	6,155	616	10	616		4,620	18
19	install electrical service for laundry.								19
20	Replace flooring in south hall bathroom	2004	2,039	204	10	204		1,326	20
21	Replaced fixtures and cabinets in soiled utility room. Repaired	2004	2,083	208	10	208		1,352	21
22	wall and doors and painted								22
23	Replace roof on south wing and northwest slope	2005	32,123		10	3,212	3,212	17,666	23
24	Install floor tile in hall, sec, conf, admin offices	2006	4,770	682	15	318	(364)	1,431	24
25	Repairs to sprinkler system	2006	8,113	811	10	811		3,650	25
26	Install floor tile in small dining room	2008	2,575		15	172	172	430	26
27	Repair asphalt, fill, seal and stripe parking lot	2008	5,100	729	5	1,020	291	2,550	27
28	Replace roof on north wing	2008	20,131		10	2,013	2,013	5,033	28
29	INSTALL FIRE DOOR AND FRAMES	2009	2,950	295	10	295		443	29
30	REPLACE COMPRESSOR IN SPRINKLER SYSTEM	2009	5,180	346	10	518	172	777	30
31	INSTALL ROOFTOP HEAT AND A/C UNIT	2010	3,900	130	15	130		130	31
32	REPAIR ACTIVITY ROOM ROOF	2010	3,810	127	10	381	254	381	32
33	INTSTALL EXTERIOR DOOR AND HARDWARE	2010	3,286	109	15	219	110	219	33
34	TOTAL (lines 1 thru 33)		\$ 1,189,135	\$ 7,607		\$ 50,300	\$ 42,693	\$ 971,191	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	\$ 76,236	\$ 7,303	\$ 8,444	\$ 1,141	VARIABLE	\$ 47,780	71
72	Current Year Purchases	15,249	2,179	658	(1,521)	VARIABLE	658	72
73	Fully Depreciated Assets	238,874				VARIABLE	238,874	73
74								74
75	TOTALS	\$ 330,359	\$ 9,482	\$ 9,102	\$ (380)		\$ 287,312	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			\$	\$ 1,557	\$ 1,557	\$		\$ 38,832	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 1,557	\$ 1,557	\$		\$ 38,832	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)	\$ 1,654,294	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,646	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 60,959	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,313	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,297,335	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? _____

16. Rental Amount for movable equipment: \$ 4,818 Description: See breakdown attached YES NO

(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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3; 39/2	hrs	\$	314	\$ 26,755	\$ 50	314	\$ 26,805	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		51	4,196		51	4,196	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		361	30,185	138	361	30,323	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				28,827		28,827	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	oxygen, tube feed, med sup Other (specify): lab, xray	39/2 39/3				4,206	29,816		34,022	13
14	TOTAL			\$	726	\$ 65,342	\$ 58,831	726	\$ 124,173	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: 01/01/2010

Ending:

12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 52,243	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	186,433		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	375,310		5
6	Prepaid Insurance	(9,913)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,400		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 608,473	\$	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	263,759		15
16	Equipment, at Historical Cost	263,008		16
17	Accumulated Depreciation (book methods)	(467,729)		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>	202,342		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 261,380	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 869,853	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,636	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,648		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,924		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>	6,578		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 91,786	\$	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)	\$ 91,786	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 778,067	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 869,853	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 902,970	1
2	Restatements (describe):		2
3			3
4	NET OPERATING LOSS CARRYBACK	17,567	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 920,537	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(142,470)	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)	\$ (142,470)	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)	\$ 778,067	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		2	
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,042,803	1
2	Discounts and Allowances for all Levels	40,638	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,083,441	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,300	6
7	Oxygen	33,584	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,884	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	1,515	19
20	Radiology and X-Ray	875	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,390	23
D. Non-Operating Revenue			
24	Contributions	15,124	24
25	Interest and Other Investment Income***	21,613	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,737	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)	\$ 2,257,452	30

1		2	
	Expenses	Amount	
A. Operating Expenses			
31	General Services	479,448	31
32	Health Care	1,038,823	32
33	General Administration	521,056	33
B. Capital Expense			
34	Ownership	195,907	34
C. Ancillary Expense			
35	Special Cost Centers	124,173	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)*	\$ 2,399,922	40
41	Income before Income Taxes (line 30 minus line 40)**	(142,470)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (142,470)	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 on 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:

01/01/2010

Ending:

12/31/2010

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	1,464	1,600	\$ 40,570	\$ 25.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,762	1,943	44,696	23.00	3
4	Licensed Practical Nurses	16,665	17,844	331,033	18.55	4
5	CNAs & Orderlies	39,723	41,799	460,156	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,066	2,170	23,983	11.05	9
10	Activity Assistants					10
11	Social Service Workers	1,968	2,171	33,617	15.48	11
12	Dietician					12
13	Food Service Supervisor	2,202	2,382	23,848	10.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,319	9,782	90,215	9.22	15
16	Dishwashers					16
17	Maintenance Workers	2,106	2,235	28,026	12.54	17
18	Housekeepers	6,365	6,895	59,300	8.60	18
19	Laundry	4,483	4,672	39,983	8.56	19
20	Administrator	1,760	1,928	53,285	27.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,190	2,278	27,192	11.94	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) WARD CLERK	1,080	1,119	9,644	8.62	33
34	TOTAL (lines 1 - 33)	93,153	98,818	\$ 1,265,548 *	\$ 12.81	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	\$ 5,435	1/3	35
36	Medical Director		2,400	9/3	36
37	Medical Records Consultant	12	752	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,724	10/3	39
40	Physical Therapy Consultant	31	1,936	10a/3	40
41	Occupational Therapy Consultant	4	252	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	291	10a/3	43
44	Activity Consultant	24	1,708	11/3	44
45	Social Service Consultant	24	1,708	12/3	45
46	Other(specify)				46
47	Purchasing Consultant		30	19/3	47
48					48
49	TOTAL (lines 35 - 48)	195	\$ 16,236		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	130	5,099	L10/C3	51
52	Certified Nurse Assistants/Aides	1,962	39,571	L10/C3	52
53	TOTAL (lines 50 - 52)	2,092	\$ 44,670		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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2005	\$ 1,984		\$ 631	\$ 316	\$	\$	\$	\$	\$	\$
2												
3												
4												
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13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,984		\$ 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? 12 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.

RECLASSIFICATION ON DPA COST REPORT
PAGES 3 & 4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	2060	
10	NURSING & MEDICAL RECORDS RECLASSIFY FOOD SUPPLEMENTS		2060
21	CLERICAL & GEN OFFICE EXPENSE	430	
10	NURSING & MEDICAL RECORDS RECLASSIFY OFFICE SUPPLIES		430
10	NURSING & MEDICAL RECORDS	702	
3	HOUSEKEEPING RECLASSIFY SOAP & SHAMPOO		702
2	FOOD PURCHASES	1226	
10	ACTIVITIES RECLASSIFY FOOD USED IN ACTIVITIES		1226
VARIOUS	VARIOUS LINE ITEMS	95493	
	PROFESSIONAL SERVICES RECLASSIFY JAMESTOWN ALLOCATION SEE SCHEDULE VIII FOR BREAKDOWN		95493

SCHEDULE OF BREAKDOWN OF MOVABLE EQUIPMENT

STORAGE	188
RECLINER	306
BEDS & MATTRESSES	3296
C-PAP MACHINE	425
WOUND VAC	540
PATIENT LIFT	25
WHEELCHAIR	<u>38</u>
	4818