		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0027342

Facility Name: CANTERBURY MANOR NURSING CENTER INC

Address: 718 N MARKET (Number) WATERLOO (City) 62298 (Zip Code)

County: MONROE

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

HFS ID Number:

Date of Initial License for Current Owners: 03/01/1970

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	940	1,448	508	2,896	8
9	SNF/PED					9
10	ICF	8,163	5,129		13,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,103	6,577	508	16,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.93%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 03/01/1970

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 508

Medicare Intermediary CGS JURISDICTION 15

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 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: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,458	6,444	5,508	123,410		123,410		123,410			1
2	Food Purchase		68,379		68,379	4,955	73,334	(278)	73,056			2
3	Housekeeping	55,740	10,514		66,254	490	66,744		66,744			3
4	Laundry	42,777	5,806		48,583		48,583		48,583			4
5	Heat and Other Utilities			72,017	72,017	595	72,612		72,612			5
6	Maintenance	28,173	16,962	57,586	102,721		102,721		102,721			6
7	Other (specify):*											7
8	**TOTAL General Services**	238,148	108,105	135,111	481,364	6,040	487,404	(278)	487,126			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	904,635	26,167	17,333	948,135	(1,753)	946,382		946,382			10
10a	Therapy			2,040	2,040		2,040		2,040			10a
11	Activities	24,115	4,213	1,858	30,186	(2,340)	27,846		27,846			11
12	Social Services	21,015		1,858	22,873		22,873		22,873			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	949,765	30,380	25,489	1,005,634	(4,093)	1,001,541		1,001,541			16
	C. General Administration											
17	Administrative	58,838			58,838	40,796	99,634		99,634			17
18	Directors Fees											18
19	Professional Services			175,444	175,444	(92,275)	83,169	(80,002)	3,167			19
20	Dues, Fees, Subscriptions & Promotions			17,739	17,739	204	17,943	(7,522)	10,421			20
21	Clerical & General Office Expenses	25,500	8,527	5,470	39,497	24,470	63,967	(255)	63,712			21
22	Employee Benefits & Payroll Taxes			175,083	175,083	10,249	185,332		185,332			22
23	Inservice Training & Education			228	228		228		228			23
24	Travel and Seminar			2,451	2,451	275	2,726		2,726			24
25	Other Admin. Staff Transportation					2,780	2,780		2,780			25
26	Insurance-Prop.Liab.Malpractice			46,940	46,940	1,866	48,806		48,806			26
27	Other (specify):*											27
28	**TOTAL General Administration**	84,338	8,527	423,355	516,220	(11,635)	504,585	(87,779)	416,806			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,272,251	147,012	583,955	2,003,218	(9,688)	1,993,530	(88,057)	1,905,473			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 INC #0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,873	14,873	3,069	17,942	46,532	64,474			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					1,425	1,425	31,012	32,437			33
34	Rent-Facility & Grounds			174,000	174,000	5,194	179,194	(174,000)	5,194			34
35	Rent-Equipment & Vehicles			2,265	2,265		2,265		2,265			35
36	Other (specify):*											36
37	TOTAL Ownership			191,138	191,138	9,688	200,826	(96,456)	104,370			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,494	68,577	112,071		112,071		112,071			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		43,494	109,092	152,586		152,586		152,586			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,272,251	190,506	884,185	2,346,942		2,346,942	(184,513)	2,162,429			45

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	23,916	30		9
10	Interest and Other Investment Income	(8,518)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(278)	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	(5)	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	(5,634)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,888)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 7,343		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(191,856)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (191,856)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (184,513)		37

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

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

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

CANTERBURY MANOR NURSING CENTER INC

ID# 0027342

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	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 INC # 0027342 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(278)	0	0	0	0	0	0	0	0	0	0	(278)	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**	(278)	0	0	0	0	0	0	0	0	0	0	(278)	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	(80,002)	0	0	0	0	0	0	0	0	0	(80,002)	19
20	Fees, Subscriptions & Promotions	(7,522)	0	0	0	0	0	0	0	0	0	0	(7,522)	20
21	Clerical & General Office Expenses	(255)	0	0	0	0	0	0	0	0	0	0	(255)	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**	(7,777)	(80,002)	0	0	0	0	0	0	0	0	0	(87,779)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,055)	(80,002)	0	0	0	0	0	0	0	0	0	(88,057)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	23,916	22,616	0	0	0	0	0	0	0	0	0	46,532	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,518)	8,518	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	31,012	0	0	0	0	0	0	0	0	0	31,012	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**	15,398	(111,854)	0	0	0	0	0	0	0	0	0	(96,456)	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)**	7,343	(191,856)	0	0	0	0	0	0	0	0	0	(184,513)	45

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMESTOWN MANAGEMENT CORP	10%	FAIR ACRES NURSING HOME	DUQUOIN	Jamestown Mgmt	Carbondale	Management
TAFFIE HELLENY	5%	FAIRVIEW NURSING CENTER	DUQUOIN	Corp		
COLETTA S. MCCLARY	42.50%					
LUCINDA J. BAIN	42.50%					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 172,433	JAMESTOWN MANAGEMENT CORPORATION	10.00%	$ 92,431	$ (80,002)	1
2	V	33	REAL ESTATE TAXES		WATERLOO LAND TRUST	100.00%	31,012	31,012	2
3	V	34	RENT	174,000	WATERLOO LAND TRUST	100.00%		(174,000)	3
4	V	32	INTEREST EXPENSE		WATERLOO LAND TRUST	100.00%	12,448	12,448	4
5	V	30	DEPRECIATION		WATERLOO LAND TRUST	100.00%	22,616	22,616	5
6	V	32	INTEREST INCOME		WATERLOO LAND TRUST	100.00%	(3,930)	(3,930)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 346,433			$ 154,577	$ * (191,856)	14

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	13,302		$ 6,874	$	2,617	$ 1,352	1
2	5	UTILITIES	HOURS OF SERVICE	13,302		3,026		2,617	595	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	7,530		207,425	207,425	1,481	40,796	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	13,302		795		2,617	156	4
5	20	LICENSES & DUES	HOURS OF SERVICE	13,302		1,039		2,617	204	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,772		110,779	110,779	1,136	21,803	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	13,302		13,556		2,617	2,667	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	13,302		52,094		2,617	10,249	8
9	24	SEMINARS	HOURS OF SERVICE	7,530		1,397		1,481	275	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	7,530		14,136		1,481	2,780	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	13,302		9,487		2,617	1,866	11
12	30	DEPRECIATION	HOURS OF SERVICE	13,302		15,602		2,617	3,069	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	13,302		7,242		2,617	1,425	13
14	34	RENT	HOURS OF SERVICE	13,302		26,400		2,617	5,194	14
15										15
16										16
17										17
18										18
19		***Excess salary of related individual has been eliminated prior to the cost report.***								19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 469,852	$ 318,204		$ 92,431	25

Facility Name & ID Number CANTERBURY MANOR NURSING CENTE # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CANTERBURY MANOR	X		1ST MORTAGE	$7,741.00	12/20/07	$ 410,559	$	04/20/2013	0.0750	$ 12,448	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	$			$ 12,448	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	$			$ 12,448	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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,012	2
3. Under or (over) accrual (line 2 minus line 1).	$	31,012	3
4. Real Estate Tax accrual used for 2011 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.	$	31,012	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	24,985	8
	2007	25,613	9
	2008	23,986	10
	2009	29,661	11
	2010	31,012	12

***Line 7 does not include the Jamestown allocation from page 8 SCHVIII of $1425.

Real estate taxes on page 4 line 33 should reconcile to line 7 $31012 + Jamestown $1425 = $32437.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CANTERBURY MANOR NURSING CENTER INC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-24-250-031-000	N. Market Street part lot 1 sur 640	$ 1,993.60	$ 1,993.60
2.	07-24-250-026-000	718 N. Market Street Tax lot 6 BA	$ 29,018.32	$ 29,018.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,011.92	$ 31,011.92

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 [X] (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 [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Original bldg & addtion	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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1970	1970	$ 123,000	$	30	$	$	$ 123,000	4
5	14		1976	1976	80,226		25			80,226	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
	Improvement Type**										
9	VARIOUS/FULLY DEPRECIATED			1970	14,327		VARIOUS			14,327	9
10	REMODELING			1974	565		25			565	10
11	NURSES CALL SYSTEM			1976	7,457		15			7,457	11
12	NURSES STATION			1976	30,851		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		15			2,565	23
24	WATER HEATER			1995	3,000		15			3,000	24
25	FIRE ALARM			1995	7,207		15			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	14	14	550	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	27	27	680	31
32	Labor/materials to remove existing and install new waterproof			1996	4,009		10			4,009	32
33	wallcovering and floor tile.										33
34	Labor/materials to remove and install new cabinets/countertops			1996	6,853		10			6,853	34
35	in nursing station.										35
36	REPAIR PLUMBING			1997	4,010	267	15	267		3,872	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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REPAIR GROUNDWATER DRAIN	1997	$ 790	$ 53	15	$ 53	$	$ 768	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	7,776	40
41	FLOORTILE AND CARPETING	1998	10,612		15	707	707	9,545	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	10,719	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, and 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	51,273	48
49	WATER SOFTENER	1998	1,400		10			1,400	49
50	FIRE SUPPRESSION SYSTEM	1998	1,356		10			1,356	50
51	GAZEBO	1999	4,084		20	204	204	2,550	51
52	COURTYARD AWNINGS	1999	850		5			850	52
53	INSTALL 911 ALARM SYSTEM	1999	519		5			519	53
54	LANDSCAPING & 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 ADDTION	1999	411,559		15	27,437	27,437	315,526	58
59	ADJUSTMENT TO 1999 COST REPORT	1999	(173)						59
60	BUILDING ADDTION	1999	17,651		15	1,177	1,177	13,535	60
61	DOOR ALARM SYSTEM	2000	5,996		10			5,996	61
62	Labor/materials to install new cabinets/countertops, relocate	2000	1,346		10			1,346	62
63	heating, elec serv and lighting in the breakroom								63
64	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10			1,071	64
65	Labor/materials to remove existing wall and relocate wall	2000	9,093		10			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		15	457	457	5,256	68
69	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789		15	386	386	4,439	69
70	TOTAL (lines 4 thru 69)		$ 1,048,383	$ 320		$ 35,897	$ 35,577	$ 934,956	70

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,048,383	$ 320		$ 35,897	$ 35,577	$ 934,956	1
2	Labor & materials to remove existing cabinetry and sinks	2000	2,845		15	190	190	2,185	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		10			1,519	7
8	ELEVATED EAST WING FLOOR/WALLS OF BUILDINGS	2001	3,875	258	15	258		2,709	8
9	Replaced employee door, frame and hardware	2001	2,129	106	10	106		2,129	9
10	Code modification to fire sprinkler system	2001	2,566	125	10	125		2,566	10
11	Installation & replacement of aluminum patio door system	2001	4,223	214	10	214		4,223	11
12	Replace pressure switch and repair lines in fire sprinkler system	2002	5,790	579	10	579		5,501	12
13	SEAL & 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		1,074	14
15	REPLACED WATER HEATER	2003	3,539		10	354	354	3,009	15
16	REPLACED WATER SOFTENER	2003	1,913		10	191	191	1,624	16
17	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898		10	290	290	2,465	17
18	Demolition and reconstruction of wall, relocated door, and	2003	6,155	616	10	616		5,236	18
19	install electrical service for laundry								19
20	Replace flooring in south hall bathroom	2004	2,039	204	10	204		1,530	20
21	Replaced fixtures & cabinets in soiled utility room.	2004	2,083	208	10	208		1,560	21
22	Repaired wall and doors and painted.								22
23	Replace roof on south wing and northwest slope	2005	32,123		10	3,212	3,212	20,878	23
24	Install floor tile in hall, sec, conf, admin offices	2006	4,770	681	15	318	(363)	1,749	24
25	Repairs to sprinkler system	2006	8,113	811	10	811		4,461	25
26	Install floor tile in small dining room	2008	2,575		15	172	172	602	26
27	Repair asphalt, fill, seal and stripe parking lot	2008	5,100	728	5	1,020	292	3,570	27
28	Replace roof on north wing	2008	20,131		10	2,013	2,013	7,046	28
29	INSTALL FIRE DOOR AND FRAMES	2009	2,950	295	10	295		738	29
30	REPLACE COMPRESSOR IN SPRINKLER SYSTEM	2009	5,180	346	10	518	172	1,295	30
31	INSTALL ROOFTOP HEAT AND A/C UNIT	2010	3,900	260	15	260		390	31
32	REPAIR ACTIVITY ROOM ROOF	2010	3,810	254	10	191	(63)	572	32
33	INSTALL EXTERIOR DOOR AND HARDWARE	2010	3,286	219	15	109	(110)	328	33
34	TOTAL (lines 1 thru 33)		$ 1,189,135	$ 6,337		$ 48,264	$ 41,927	$ 1,019,455	34

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,189,135	$ 6,337		$ 48,264	$ 41,927	$ 1,019,455	1
2	Replace sprinkler system throughout building, except	2011	73,742	612	25	1,475	863	1,475	2
3	administrative wing								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	TOTAL (lines 1 thru 33)		$ 1,262,877	$ 6,949		$ 49,739	$ 42,790	$ 1,020,930	34

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 67,895	$ 7,175	$ 11,398	$ 4,223	VARIABLE	$ 36,246	71
72	Current Year Purchases	3,423	749	268	(481)	VARIABLE	268	72
73	Fully Depreciated Assets	262,464				VARIABLE	262,464	73
74								74
75	TOTALS	$ 333,782	$ 7,924	$ 11,666	$ 3,742		$ 298,978	75

D. Vehicle Costs. (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			$	$ 3,069	$ 3,069	$		$ 41,901	76
77										77
78										78
79										79
80	TOTALS			$	$ 3,069	$ 3,069	$		$ 41,901	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)	$ 1,731,459	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,942	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 64,474	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 46,532	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,361,809	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 2,265 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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

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

   WE ONLY HIRE TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
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.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3;39/2	hrs	$	319	$ 26,357	$ 25	319	$ 26,382	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		127	10,583	0	127	10,583	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		324	28,586	112	324	28,698	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				22,778		22,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	oxygen, med sup, tube feed Other (specify): lab, xray	39/2 39/3				3,051	20,579		23,630	13
14	TOTAL			$	770	$ 68,577	$ 43,494	770	$ 112,071	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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 48,555	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	472,597		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	74,134		5
6	Prepaid Insurance	1,709		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 596,995	$	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	337,501		15
16	Equipment, at Historical Cost	266,431		16
17	Accumulated Depreciation (book methods)	(482,602)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 121,330	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 718,325	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,051	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,015		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,284		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	401k Liability	7,064		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 127,414	$	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)**	$ 127,414	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 590,911	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 718,325	$	48

***(See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 778,067	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 778,067	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(187,156)	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)**	$ (187,156)	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)**	$ 590,911	24	*

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

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER IN(# 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,965,209	1
2	Discounts and Allowances for all Levels	16,561	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,981,770	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,360	6
7	Oxygen	21,043	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 144,403	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	1,394	19
20	Radiology and X-Ray	500	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,894	23
	D. Non-Operating Revenue		
24	Contributions	15,376	24
25	Interest and Other Investment Income***	16,343	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,719	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)**	$ 2,159,786	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	481,364	31
32	Health Care	1,005,634	32
33	General Administration	516,220	33
	B. Capital Expense		
34	Ownership	191,138	34
	C. Ancillary Expense		
35	Special Cost Centers	112,071	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)***	$ 2,346,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	(187,156)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (187,156)	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.** **Illinois taxes are deduc 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 INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,788	2,080	$ 50,155	$ 24.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,103	3,249	70,705	21.76	3
4	Licensed Practical Nurses	14,079	15,823	296,011	18.71	4
5	CNAs & Orderlies	38,431	41,060	478,377	11.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,954	2,084	24,115	11.57	9
10	Activity Assistants					10
11	Social Service Workers	1,603	1,619	21,015	12.98	11
12	Dietician					12
13	Food Service Supervisor	2,098	2,196	22,323	10.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,724	9,158	89,135	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,897	2,146	28,173	13.13	17
18	Housekeepers	5,997	6,332	55,740	8.80	18
19	Laundry	4,334	4,695	42,777	9.11	19
20	Administrator	1,920	2,360	58,838	24.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,959	2,167	25,500	11.77	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	968	1,069	9,387	8.78	33
34	TOTAL (lines 1 - 33)	88,855	96,038	$ 1,272,251 *	$ 13.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	91	$ 5,508	1/3	35
36	Medical Director		2,400	9/3	36
37	Medical Records Consultant	12	756	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,482	10/3	39
40	Physical Therapy Consultant	22	1,380	10a/3	40
41	Occupational Therapy Consultant	2	100	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	560	10a/3	43
44	Activity Consultant	26	1,858	11/3	44
45	Social Service Consultant	26	1,858	12/3	45
46	Other(specify) Administrative Cons		400	19/3	46
47	Purchasing Consultant		98	19/3	47
48	Billing Consultant		1,718	19/3	48
49	TOTAL (lines 35 - 48)	187	$ 18,118		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	L10/C3	50
51	Licensed Practical Nurses	8	284	L10/C3	51
52	Certified Nurse Assistants/Aides	717	14,811	L10/C3	52
53	TOTAL (lines 50 - 52)	725	$ 15,095		53

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PATSY MORRIS	ADMINISTRATOR	0	$ 46,381
TIMOTHY JOHNSON	ADMINISTRATOR	0	12,457
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,838

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MANAGEMENT	MANAGEMENT	$ 172,433
BARNETT & LEVINE	ACCOUNTING	795
INNOVATIVE LTC SOLUTIONS	BILLING	1,718
MES	PURCHASING	98
JOHN HUELSKAMP	ADMINISTRATIVE CONSULT	400
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 175,444

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,299
Unemployment Compensation Insurance	12,272
FICA Taxes	97,327
Employee Health Insurance	4,580
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSES	10,141
VACCINES	750
AWARDS, ATTENDANCE, PARTIES, ECT	1,886
BONUSES	6,828
JAMESTOWN ALLOCATION	10,249
TOTAL (agree to Schedule V, line 22, col.8)	$ 185,332

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,409
Advertising: Employee Recruitment	3,329
Health Care Worker Background Check	648
(Indicate # of checks performed 54)	
Patient Background Checks 52	580
JAMESTOWN ALLOCATION	204
SUBSCR 480; OTHER ADV 7522	8,002
CORP FEES 623; DON DUES 30	653
ALLSCRIPTS 2869; INHAA 100	2,969
KITCHEN COMPLIANCE REVIEW	149
Less: Public Relations Expense	(5,634)
Non-allowable advertising	( )
Yellow page advertising	(1,888)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,421

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	821
Seminar Expense	1,630
JAMESTOWN ALLOCATION	275
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,726

**See instructions.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINTING	2005	$ 1,984	3	$ 631	$ 316	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,984		$ 631	$ 316	$	$	$	$	$	$	$

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER INC # 0027342 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 politica 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? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo 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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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 fo 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 othe 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
12/31/2011

RECLASSIFICATION ON DPA COST REPORT
PAGES 3 & 4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	2615	
10	NURSING & MEDICAL RECORDS		2615
	RECLASSIFY FOOD SUPPLEMENTS		
10	NURSING & MEDICAL RECORDS	862	
3	HOUSEKEEPING		862
	RECLASSIFY SOAP & SHAMPOO		
2	FOOD PURCHASES	2340	
10	ACTIVITIES		2340
	RECLASSIFY FOOD USED IN ACTIVITIES		
VARIOUS	VARIOUS LINE ITEMS	92431	
	PROFESSIONAL SERVICES		92431
	RECLASSIFY JAMESTOWN ALLOCATION		
	SEE SCHEDULE VIII FOR BREAKDOWN		

CANTERBURY MANOR NURSING CENTER INC #0023742
12/31/2011

SCHEDULE OF BREAKDOWN OF MOVABLE EQUIPMENT

STORAGE	188
BED FRAME	1991
SUCTION MACHINE	35
MATRESS OVERLAY A.P.P SYSTEM	26
FLOOR BUFFER	25
TOTAL MOVABLE EQUIPMENT	2265