

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>207</u>	Skilled (SNF)	<u>207</u>	<u>75,555</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>207</u>	TOTALS	<u>207</u>	<u>75,555</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>67,253</u>		<u>1,340</u>	<u>68,593</u>	8
9	SNF/PED					9
10	ICF		<u>4,745</u>		<u>4,745</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,253</u>	<u>4,745</u>	<u>1,340</u>	<u>73,338</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.07%

D. How many bed-hold days during this year were paid by the Department? 183 (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)
N/A

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 2/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 207 and days of care provided 1,278

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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	273,937	22,642	8,275	304,854		304,854		304,854		1
2	Food Purchase		357,243		357,243		357,243	(6,759)	350,484		2
3	Housekeeping	287,682	40,999		328,681		328,681		328,681		3
4	Laundry			35,085	35,085		35,085		35,085		4
5	Heat and Other Utilities			296,977	296,977		296,977	6,119	303,096		5
6	Maintenance	125,093	106,497		231,590		231,590	6,209	237,799		6
7	Other (specify):*										7
8	TOTAL General Services	686,712	527,381	340,337	1,554,430		1,554,430	5,569	1,559,999		8
	B. Health Care and Programs										
9	Medical Director			35,000	35,000		35,000		35,000		9
10	Nursing and Medical Records	2,189,596	77,128	13,096	2,279,820		2,279,820		2,279,820		10
10a	Therapy	144,008	117	1,294	145,419		145,419		145,419		10a
11	Activities	63,424	7,679	1,045	72,148		72,148		72,148		11
12	Social Services	188,654		268	188,922		188,922		188,922		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,585,682	84,924	50,703	2,721,309		2,721,309		2,721,309		16
	C. General Administration										
17	Administrative	255,023		628,320	883,343		883,343	(65,492)	817,851		17
18	Directors Fees										18
19	Professional Services			540,464	540,464		540,464	(340,111)	200,353		19
20	Dues, Fees, Subscriptions & Promotions			27,148	27,148		27,148	(10,034)	17,114		20
21	Clerical & General Office Expenses	207,809	25,522	74,754	308,085		308,085	83,440	391,525		21
22	Employee Benefits & Payroll Taxes			447,361	447,361		447,361		447,361		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,620	3,620		3,620	463	4,083		24
25	Other Admin. Staff Transportation			14,350	14,350		14,350	7,660	22,010		25
26	Insurance-Prop.Liab.Malpractice			196,847	196,847		196,847	1,078	197,925		26
27	Other (specify):*							30,210	30,210		27
28	TOTAL General Administration	462,832	25,522	1,932,864	2,421,218		2,421,218	(292,786)	2,128,432		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,735,226	637,827	2,323,904	6,696,957		6,696,957	(287,217)	6,409,740		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 WOOD GLEN NURSING & REHAB CTR #0043935 Report Period Beginning: 1/1/09 Ending: 12/31/09

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 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			71,604	71,604		71,604	125,326	196,930		30
31	Amortization of Pre-Op. & Org.							285	285		31
32	Interest			27,839	27,839		27,839	272,981	300,820		32
33	Real Estate Taxes			273,079	273,079		273,079		273,079		33
34	Rent-Facility & Grounds			1,189,092	1,189,092		1,189,092	(1,189,092)			34
35	Rent-Equipment & Vehicles			29,445	29,445		29,445	943	30,388		35
36	Other (specify):*							3,759	3,759		36
37	TOTAL Ownership			1,591,059	1,591,059		1,591,059	(785,798)	805,261		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			47,272	47,272		47,272		47,272		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			113,333	113,333		113,333		113,333		42
43	Other (specify):*							(50,691)	(50,691)		43
44	TOTAL Special Cost Centers			160,605	160,605		160,605	(50,691)	109,914		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,735,226	637,827	4,075,568	8,448,621		8,448,621	(1,123,706)	7,324,915		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,753)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	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				18
19	Entertainment				19
20	Contributions	(2,525)	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	(4,773)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,808)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(394,366)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (421,235)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(702,471)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (702,471)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,123,706)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

WOOD GLEN NURSING & REHAB CTR

ID# 0043935

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	BANK FEES	\$ (17,920)	21	1
2	TAXES - GENERAL	(318)	21	2
3	DAMAGE/THEFT/LOSS	(714)	21	3
4	IL COUNCIL LTC - COPE	(6,227)	20	4
5	MARKETING SALARIES	(45,269)	43	5
6	MARKETING EMPLOYEE BENEFITS	(5,422)	43	6
7	TRAVEL - PH ECLIPSE	(7,140)	25	7
8	NONALLOWABLE SETTLEMENT	(350,000)	19	8
9	ADJ TO S/L DEPR	41,281	30	9
10	REAL ESTATE TAXES	(2,637)	33	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	(394,366)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR# 0043935

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(6,759)	0	0	0	0	0	0	0	0	0	0	(6,759)	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	6,119	0	0	0	0	0	0	0	0	6,119	5
6	Maintenance	0	0	6,209	0	0	0	0	0	0	0	0	6,209	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,759)	0	12,328	0	5,569	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	(65,492)	0	0	0	0	0	0	0	0	(65,492)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(350,000)	0	9,889	0	0	0	0	0	0	0	0	(340,111)	19
20	Fees, Subscriptions & Promotions	(11,000)	0	966	0	0	0	0	0	0	0	0	(10,034)	20
21	Clerical & General Office Expenses	(34,285)	0	117,725	0	0	0	0	0	0	0	0	83,440	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	463	0	0	0	0	0	0	0	0	463	24
25	Other Admin. Staff Transportation	(7,140)	0	14,800	0	0	0	0	0	0	0	0	7,660	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,078	0	0	0	0	0	0	0	0	1,078	26
27	Other (specify):*	0	0	30,210	0	0	0	0	0	0	0	0	30,210	27
28	TOTAL General Administration	(402,425)	0	109,639	0	(292,786)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(409,184)	0	121,967	0	(287,217)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	41,281	80,405	3,640	0	0	0	0	0	0	0	0	125,326	30
31	Amortization of Pre-Op. & Org.	0	0	285	0	0	0	0	0	0	0	0	285	31
32	Interest	(4)	268,970	4,015	0	0	0	0	0	0	0	0	272,981	32
33	Real Estate Taxes	(2,637)	0	2,637	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,189,092)	0	0	0	0	0	0	0	0	0	(1,189,092)	34
35	Rent-Equipment & Vehicles	0	0	943	0	0	0	0	0	0	0	0	943	35
36	Other (specify):*	0	3,759	0	0	0	0	0	0	0	0	0	3,759	36
37	TOTAL Ownership	38,640	(835,958)	11,520	0	(785,798)	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):*	(50,691)	0	0	0	0	0	0	0	0	0	0	(50,691)	43
44	TOTAL Special Cost Centers	(50,691)	0	0	0	0	0	0	0	0	0	0	(50,691)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(421,235)	(835,958)	133,487	0	0	0	0	0	0	0	0	(1,123,706)	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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENTAL INCOME	\$ 1,189,092	WOOD GLEN PAVILION REALTY, LLC		\$	(1,189,092)	1
2	V	30 DEPRECIATION				80,405	80,405	2
3	V	32 INTEREST				268,970	268,970	3
4	V	36 AMORTIZATION-LOAN COSTS				3,759	3,759	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,189,092			\$ 353,134	\$ * (835,958)	14

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

VII. RELATED PARTIES (continued)

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)
15	V	17 Home Office	\$ 148,320	Platinum Health Care, LLC	100.00%	\$	\$ (148,320)
16	V	5 Utilities		Platinum Health Care, LLC		6,119	6,119
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		6,209	6,209
18	V	17 Administrative Salary		Platinum Health Care, LLC		82,828	82,828
19	V	19 Professional Fees		Platinum Health Care, LLC		9,889	9,889
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		966	966
21	V	21 Clerical Salaries		Platinum Health Care, LLC		102,803	102,803
22	V	21 Office Expenses		Platinum Health Care, LLC		14,922	14,922
23	V	24 Education & Seminars		Platinum Health Care, LLC		463	463
24	V	25 Travel		Platinum Health Care, LLC		14,800	14,800
25	V	26 Insurance		Platinum Health Care, LLC		1,078	1,078
26	V	27 Employee Benefits		Platinum Health Care, LLC		30,210	30,210
27	V	30 Depreciation		Platinum Health Care, LLC		1,413	1,413
28	V	35 Equipment Rental		Platinum Health Care, LLC		943	943
29	V	31 Amortization		Platinum Health Care, LLC		285	285
30	V	30 Depreciation		Platinum Health Care, LLC		2,227	2,227
31	V	32 Interest		Platinum Health Care, LLC		4,015	4,015
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		2,637	2,637
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 148,320			\$ 281,807	\$ * 133,487

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

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR** # **0043935** Report Period Beginning: **1/1/09** Ending: **12/31/09**

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	BEN KLEIN		Administrative	70.10	SEE ATTACHED	2	5.00	Mgt Fees	\$ 480,000	17-3	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	\$ 480,000		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 WOOD GLEN NURSING & REHAB CTR # 0043935 Report Period Beginning: 1/1/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Platinum Health Care, LLC
 Street Address 7444 Long Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 329-4100
 Fax Number (847) 329-7652

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.

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	5	Utilities	Patient Days	606,157	15	\$ 50,576	\$ 73,338	\$ 6,119	1
2	6	Repairs & Maintenance	Patient Days	606,157	15	51,318	73,338	6,209	2
3	17	Administrative Salary	Patient Days	606,157	15	684,597	684,597	82,828	3
4	19	Professional Fees	Patient Days	606,157	15	81,733	73,338	9,889	4
5	20	Fees, Subscriptions	Patient Days	606,157	15	7,987	73,338	966	5
6	21	Clerical Salaries	Patient Days	606,157	15	849,689	849,689	102,803	6
7	21	Office Expenses	Patient Days	606,157	15	123,336	73,338	14,922	7
8	24	Education & Seminars	Patient Days	606,157	15	3,826	73,338	463	8
9	25	Travel	Patient Days	606,157	15	122,325	73,338	14,800	9
10	26	Insurance	Patient Days	606,157	15	8,909	73,338	1,078	10
11	27	Employee Benefits	Patient Days	606,157	15	249,694	73,338	30,210	11
12	30	Depreciation	Patient Days	606,157	15	11,677	73,338	1,413	12
13	35	Equipment Rental	Patient Days	606,157	15	7,792	73,338	943	13
14	31	Amortization	Patient Days	606,157	15	2,355	73,338	285	14
15	30	Depreciation	Patient Days	606,157	15	18,405	73,338	2,227	15
16	32	Interest	Patient Days	606,157	15	33,183	73,338	4,015	16
17	33	Real Estate Taxes	Patient Days	606,157	15	21,795	73,338	2,637	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,329,197	\$ 1,534,286	\$ 281,807	25

Facility Name & ID Number

WOOD GLEN NURSING & REHAB CTR

0043935

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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		X	Mortgage			\$	\$		\$ 268,970	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Bank of America	X	Line of Credit						27,839	6									
7										7									
8										8									
9	TOTAL Facility Related					\$	\$		\$ 296,809	9									
B. Non-Facility Related*																			
10	Interest Income Offset								(4)	10									
11										11									
12										12									
13	Allocation from Platinum								4,015	13									
14	TOTAL Non-Facility Related					\$	\$		\$ 4,011	14									
15	TOTALS (line 9+line14)					\$	\$		\$ 300,820	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,112 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

1. Real Estate Tax accrual used on 2008 report.		\$	254,000	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.)		\$	263,079	2
3. Under or (over) accrual (line 2 minus line 1).		\$	9,079	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	264,000	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.		\$	273,079	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	172,300	8	
	2005	190,000	9	
	2006	200,113	10	
	2007	252,405	11	
	2008	263,079	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		1994	\$ 465,000	1
2					2
3	TOTALS			\$ 465,000	3

Facility Name & ID Number **WOOD GLEN NURSING & REHAB CTR**

0043935

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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		1995	1995	\$ 3,067,125	\$ 78,645	35	\$ 87,632	\$ 8,987	\$ 1,225,651
5									
6									
7									
8									
Improvement Type**									
9	FENCE		1998	5,042	337	15	337		4,253
10	FIRE ALARM		2002	44,058		20	2,203	2,203	34,807
11									
12	Various		1995	25,326		20	1,266	1,266	18,470
13	Various		1996	16,672		20	834	834	11,049
14	Various		1997	20,310		20	1,016	1,016	12,736
15	Various		1998	22,766		20	1,138	1,138	15,186
16					1,423			(1,423)	
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LOBBY IMPROVEMENTS	1999	\$ 3,750	\$	20	\$ 188	\$ 188	\$ 1,908	37
38	WATER HEATER	1999	4,100		20	205	205	2,081	38
39	CONTRACTOR	1999	919		20	46	46	483	39
40	PUMP	1999	1,887		20	94	94	946	40
41	MATV SYSTEM	1999	752		20	38	38	380	41
42	PRESSURE SWITCH	1999	1,341		20	67	67	670	42
43	BOILER	1999	1,964		20	98	98	980	43
44	AIR CONDITIONER	1999	612		20	31	31	310	44
45	SMOKE DETECTOR	1999	3,118		20	156	156	1,560	45
46	FIRE ALARM SYSTEM	1999	693		20	35	35	449	46
47	2 WATER HEATERS	2000	8,400		20	420	420	4,130	47
48	FLOORING	2000	1,284		20	64	64	597	48
49	CARPET	2000	1,284		20	64	64	592	49
50	FLOORING	2000	3,740		20	187	187	1,730	50
51	CARPET	2000	5,225		20	261	261	2,371	51
52	FIXTURES (\$31,000 REMOVED 2008 CAP COST AUDIT)	2000							52
53	FLUID PUMP	2000	2,429		20	121	121	1,170	53
54	FLUID PUMP	2000	905		20	45	45	435	54
55	FLUID PUMP SVC	2000	2,412		20	121	121	1,149	55
56	WATER LINES & DRAIN	2001	3,870		39	99	99	887	56
57	BURNER PILOT & PARTS	2001	1,593		39	41	41	367	57
58	4 DUPLEX OUTLETS	2001	2,275		39	58	58	520	58
59	WATER HEATER PIPING	2001	8,997		39	231	231	2,031	59
60	FLUES - WATER BOILER	2001	3,580		39	92	92	771	60
61	BRICK WALL	2001	4,515		39	116	116	952	61
62	EXPANSION MODULE	2001	947		20	47	47	403	62
63	CABLES	2001	1,031		20	52	52	420	63
64	CABLE WORK	2001	767		20	38	38	307	64
65	PHONES/CABLES	2001	544		20	27	27	243	65
66	LIGHTING	2001	1,022		20	51	51	412	66
67	LAMPS (\$742 TO MME PER '08 CAP COST AUDIT)	2001			20				67
68	FIRE PUMP WORK	2001	750		20	38	38	307	68
69	HEATING/COOLING WORK	2001	649		20	32	32	259	69
70	TOTAL (lines 4 thru 69)		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,351,972	70

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,276,654	\$ 80,405		\$ 97,589	\$ 17,184	\$ 1,351,972	1
2	LIGHTING	2001	903		20	45	45	371	2
3	MOTOR	2001	547		20	27	27	239	3
4	LIGHTING ENHANCEMENT	2001	903		20	45	45	386	4
5	REFRIGERATOR WORK	2001	1,044		20	52	52	429	5
6	PIPE WORK	2001	500		20	25	25	206	6
7	CONCRETE ANCHOR	2001	5,332		20	267	267	2,292	7
8	REFRIGERATOR WORK	2001	532		20	27	27	230	8
9	REFRIGERATOR WORK	2001	585		20	29	29	242	9
10	LIGHTING	2001	903		20	45	45	405	10
11	LIGHTING	2001	903		20	45	45	401	11
12	LIGHTING	2001	903		20	45	45	398	12
13	LIGHTING	2001	903		20	45	45	394	13
14	LIGHTING	2001	903		20	45	45	390	14
15	PUMP	2001	571		20	29	29	234	15
16	HEAT PUMP MOTOR	2001	1,409		20	70	70	572	16
17	PLUMBING	2001	1,038		20	52	52	468	17
18	PATIO	2002	2,250		10	225	225	1,706	18
19	A/C REPAIR	2002	3,529		10	353	353	2,677	19
20	A/C REPAIR	2002	1,305		10	131	131	982	20
21	A/C REPAIR	2002	1,240		10	124	124	920	21
22	A/C REPAIR	2002	888		10	89	89	638	22
23	A/C REPAIR	2002	846		10	85	85	602	23
24	A/C REPAIR	2002	664		10	66	66	495	24
25	WATER HEATERS	2002	1,700		10	170	170	1,289	25
26	WATER HEATERS	2002	2,460		10	246	246	1,866	26
27	FREEZER REPAIR	2002	587		20	29	29	232	27
28	FIRE PUMP WORK	2002	750		20	38	38	304	28
29	SERVICE PUMP	2002	540		20	27	27	216	29
30	ELECTRICAL SYSTEM	2002	528		20	26	26	208	30
31	PIPE WORK	2002	1,213		20	61	61	488	31
32	LIGHTING ENHANCEMENT	2002	12,442		20	622	622	4,976	32
33	MAIN ENTRANCE CAMERA	2003	13,445		5			13,445	33
34	TOTAL (lines 1 thru 33)		\$ 3,338,920	\$ 80,405		\$ 100,774	\$ 20,369	\$ 1,390,673	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,338,920	\$ 80,405		\$ 100,774	\$ 20,369	\$ 1,390,673	1
2	PROXIMITY READERS	2003	2,074		5			2,074	2
3	PROXIMITY READERS/SMART	2003	3,805		5			3,805	3
4	WALL DECORATION	2003	1,063		5			1,063	4
5	KITCHEN WORK	2003	1,454		10	145	145	991	5
6	CI RANG STEAM	2003	869		10	87	87	544	6
7	CI RANG STEAM	2003	2,289		10	229	229	1,431	7
8	DRAPES	2003	2,525		5			2,525	8
9	FROZEN COIL IN AIR HANDLER	2004	3,819		10	382	382	2,292	9
10	WATER HEATER	2004	8,714		10	871	871	5,081	10
11	INSTALL NEW COIL	2004	3,800		10	380	380	2,153	11
12	CONDENSING UNIT	2004	4,200		15	280	280	1,540	12
13	PLUMBING-DIALYSIS ROOM	2004	5,390		20	270	270	1,485	13
14	WATER HEATER	2004	6,748		10	675	675	3,712	14
15	SERVICE PUMP	2004	7,565		20	378	378	2,048	15
16	BOILER & STORAGE TANKS	2004	6,200		20	310	310	1,757	16
17	CHASE WALLS	2004	4,570		15	305	305	1,601	17
18	CARPETING	2004	12,311		5	1,847	1,847	12,311	18
19	HOT WATER TANK	2004	11,242		10	1,124	1,124	5,901	19
20	WATER TANK	2004	34,751		20	1,738	1,738	8,980	20
21	HOT WATER VALVE	2004	3,609		20	180	180	945	21
22	CARPETING	2004	28,726		5	4,310	4,310	28,726	22
23	HOT WATER BOILER	2004	7,344		20	367	367	1,835	23
24	ALUMINUM STREET SIGN DISP	2005	3,700		10	370	370	1,850	24
25	FIRE ALARMS/SMOKE DETECTORS	2005	2,134		10	213	213	1,048	25
26	TURNBURY INSULATED DOME	2005	1,545		10	155	155	762	26
27	STEEL PEDESTRIAN DOORS	2005	4,630		20	232	232	1,140	27
28	RED OAK UNFINISHED DOO	2005	1,580		15	105	105	508	28
29	FIRE DAMPERS	2005	5,294		10	529	529	2,513	29
30	SECURITY SYSTEM	2005	16,519		10	1,652	1,652	7,709	30
31	SMOKE DAMPER MOTORS	2005	7,524		10	752	752	3,510	31
32	ASPHALT REPLACEMENT	2005	10,862		8	1,358	1,358	6,224	32
33	SMOKE DAMPER MOTORS	2005	2,585		10	259	259	1,187	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,361	\$ 80,405		\$ 120,277	\$ 39,872	\$ 1,509,924	34

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,558,361	\$ 80,405		\$ 120,277	\$ 39,872	\$ 1,509,924	1
2	BOILER REPLACEMENT	2005	18,998		20	950	950	4,117	2
3	SECURITY SYSTEM	2005	2,400		10	240	240	1,020	3
4	FIRE ALARM DEVICES INSTALL	2005	4,687		10	469	469	1,993	4
5	HOT WATER HEATER EXCHAN	2005	27,374		10	2,737	2,737	11,404	5
6	VINYL FENCE & WALK GATE	2005	3,844		10	384	384	1,600	6
7	SATELLITE TV & INTERNET (\$12,699 TO MME '08 CC AUDI	2005							7
8	DOOR HOLDERS	2006	3,324		10	332	332	1,301	8
9	HOT WATER COILS-OFFICE	2006	4,472		10	447	447	1,714	9
10	ADD CONCRETE TO PATIO	2006	8,476		15	565	565	2,072	10
11	ROOF WORK	2006	4,560		20	228	228	817	11
12	EGRESS DOORS	2006	1,651		10	165	165	578	12
13	DOORS	2006	1,631		10	163	163	1,308	13
14	CABLE,SPLITTERS, WALL PLA	2006	16,577		20	829	829	2,487	14
15	ALARM & SPRINKLER INSPECTION (\$3,640 REMOVED '08 C	2007							15
16	FAN COIL UNIT	2007	5,215		10	522	522	1,348	16
17	PEERLESS FENCE	2007	2,576		15	172	172	444	17
18	SEALCOATING & CRACK SEALING	2007	4,525		8	566	566	1,273	18
19	PS-35 PYROTRONICS POWER SUPPLY (41,992 REM '08 CC A	2007							19
20	DOORS	2007	2,585		10	259	259	540	20
21	CHILLER	2008	106,846		10	10,685	10,685	15,137	21
22	AIR HANDLER/PNEUMATIC CONTROL	2008	3,300		10	330	330	632	22
23	INSTALL DOORS (1ST-3RD FLOOR)	2008	2,597		10	260	260	498	23
24	COMDIAL MP5000	2008	14,730		10	1,473	1,473	2,823	24
25	CHILLER REPLACEMENT PROJ	2008	9,740		10	974	974	1,786	25
26	INSTALL DOORS (LINEN/GARBAGE))	2008	2,212		10	221	221	387	26
27	FIRE SPRINKLER SUBCONTRACTOR	2008	6,965		10	697	697	1,161	27
28	INSTALL NEW CONDENSER & EVAPORATOR	2008	6,191		10	619	619	1,032	28
29	SECURTY UNIT	2008	6,740		10	674	674	1,067	29
30	REPAIR FIRE PUMP RUN TIMER	2008	6,318		10	632	632	895	30
31	POWER SUPPLY & DOME CAMERA	2008	1,099		10	110	110	110	31
32	REPAIR/REPLACE THERMOSTATIC VALVE-HOT WATER S	2008	3,086		10	309	309	309	32
33	BOILER REPAIR	2009	33,860		10	1,270	1,270	1,270	33
34	TOTAL (lines 1 thru 33)		\$ 3,874,940	\$ 80,405		\$ 147,556	\$ 67,151	\$ 1,571,044	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,874,940	\$ 80,405		\$ 147,556	\$ 67,151	\$ 1,571,044	1
2	CHILLER REPLACEMENT	2009	136,577		10	8,331	8,331	8,331	2
3	REMOVE/REPLACE RUBBER WALL DETAIL	2009	2,900		10				3
4	INSTALL NEW DOORS & MAGNETIC CLOSERS	2009	6,987		10				4
5	BACKUP GENSET-REPLACE COOLANT, HTR HOSES, FILT	2009	1,205		10				5
6	PLUMBING-TWIST N CLOSE BATH WASTE	2009	1,086		10				6
7	ENTRY HEAT REMOVED/CLEANED BLOWERS	2009	2,547		10				7
8	BOILER #1 REPAIR	2009	4,138		10				8
9	FIRE ALARM REPAIR	2009	8,413		10				9
10	SPRINKLER REPAIR/REPLACE HEADS	2009	5,593		10				10
11	SPRINKLER INSPECTION	2009	2,282		10				11
12	REPAIR PLUMBING LEAKS	2009	776		10				12
13				28,563			(28,563)		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)		\$ 4,047,444	\$ 108,968		\$ 155,887	\$ 46,919	\$ 1,579,375	34

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

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$ 4,047,444	\$ 108,968		\$ 155,887	\$ 46,919	\$ 1,579,375	1
2	ALLOCATIONS FROM PLATINUM (HO):								2
3	BUILDING (CONSTRUCTED 1955; PURCH 2004)	2004	34,281						3
4	FIRE ALARM & SECURITY SYSTEM	2004	214						4
5	PAINTING	2004	230						5
6	CARPETING	2004	480						6
7	BLINDS	2004	113						7
8	BLINDS	2005	165						8
9	REMODELING-FLOORS, LIGHTS, PLUMBING & WALLS	2005	1,645						9
10	REMODELING-WALLS	2005	66						10
11	BATHROOM REMODELING	2005	165						11
12	BATHROOM REMODELING	2005	240						12
13	BATHROOM REMODELING	2006	938						13
14	WINDOWS	2006	411						14
15	TUCK POINTING	2008	138						15
16	REMODEL PARESH'S OFFICE	2008	507						16
17	HEAT EXCHANGER	2009	470						17
18	RENZOR UNIT HEATER	2009	472						18
19	RELOCATION OF STAT FOR NW UNIT HEATER	2009	93						19
20	REMODEL BOOKKEEPING OFFICE	2009	507						20
21	AWNING	2009	1,000						21
22	PARKING LOT REPAIR	2009	387						22
23				1,460		1,460			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)		\$ 4,089,966	\$ 110,428		\$ 157,347	\$ 46,919	\$ 1,579,375	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	\$ 382,768	\$ 16,490	\$ 30,351	\$ 13,861	VARIOUS	\$ 289,233	71
72	Current Year Purchases	39,407	23,802	1,472	(22,330)		1,472	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		2,180	2,180				74
75	TOTALS	\$ 422,175	\$ 42,472	\$ 34,003	\$ (8,469)		\$ 290,705	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		FRANKS CHEVROLET	1996	\$ 6,461	\$	\$	\$	5	\$ 6,461	76
77		BUS	2002	8,447				5	8,447	77
78		GMC SIERRA	2004	30,357	874		(874)	4	30,357	78
79		WG VAN	2005	26,782	1,875	5,580	3,705	4	26,782	79
80	TOTALS			\$ 72,047	\$ 2,749	\$ 5,580	\$ 2,831		\$ 72,047	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 5,049,188	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 155,649	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 196,930	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,942,127	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ **16,399** Description: **SEE ATTACHED SCHEDULE**

(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			\$ SEE ATTACHED SCHEDULE	\$ 13,046	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 13,046	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-03	hrs	\$	4	\$ 306	\$	4	\$ 306	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		14	988		14	988	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				41,375		41,375	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab</u>	39-02					5,897		5,897	13
14	TOTAL			\$	18	\$ 1,294	\$ 47,272	18	\$ 48,566	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 127	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>54,070</u>)	1,425,536		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,668		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)	\$ 1,505,331	\$	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	856,338		15
16	Equipment, at Historical Cost	369,965		16
17	Accumulated Depreciation (book methods)	(501,244)		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):	1,158,699		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,883,758	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,389,089	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 235,502	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	950,000		29
30	Accrued Salaries Payable	151,464		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	264,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	21,263		36
37	<u>Due Others, Adv Billing</u>	275,710		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,897,939	\$	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)	\$ 1,897,939	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,491,150	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,389,089	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,175,130	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,175,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	716,020	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	(400,000)	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)	\$ 316,020	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)	\$ 1,491,150	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,752,268	1
2	Discounts and Allowances for all Levels	(34,887)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,717,381	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	386,715	6
7	Oxygen	500	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,215	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	6,753	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,093	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,195	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,041	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	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)	\$ 9,164,641	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,554,430	31
32	Health Care	2,721,309	32
33	General Administration	2,421,218	33
B. Capital Expense			
34	Ownership	1,591,059	34
C. Ancillary Expense			
35	Special Cost Centers	47,272	35
36	Provider Participation Fee	113,333	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,448,621	40
41	Income before Income Taxes (line 30 minus line 40)**	716,020	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 716,020	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. Tax Return filed on Cash Basis

*** 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 **WOOD GLEN NURSING & REHAB CTR**

0043935

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	1,912	2,081	\$ 120,493	\$ 57.90	1
2	Assistant Director of Nursing	3,000	3,160	109,750	34.73	2
3	Registered Nurses	22,364	23,781	755,656	31.78	3
4	Licensed Practical Nurses	11,852	12,516	335,725	26.82	4
5	CNAs & Orderlies	56,925	59,805	817,266	13.67	5
6	CNA Trainees					6
7	Licensed Therapist	861	861	43,700	50.75	7
8	Rehab/Therapy Aides	2,927	3,111	100,308	32.24	8
9	Activity Director	256	328	8,267	25.20	9
10	Activity Assistants	5,803	5,963	55,157	9.25	10
11	Social Service Workers	9,844	10,348	188,654	18.23	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,120	66,408	31.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,146	22,509	207,529	9.22	15
16	Dishwashers					16
17	Maintenance Workers	12,446	13,146	125,093	9.52	17
18	Housekeepers	31,687	33,895	287,682	8.49	18
19	Laundry					19
20	Administrator	1,888	2,082	255,023	122.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,872	6,366	207,809	32.64	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	3,589	3,887	50,706	13.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,348	205,959	\$ 3,735,226 *	\$ 18.14	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	155	\$ 8,275	01-03	35
36	Medical Director	Monthly	35,000	09-03	36
37	Medical Records Consultant	Quarterly	1,536	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		11,560	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,000	11-03	44
45	Social Service Consultant	4	268	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	175	\$ 57,639		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
JEFF WHITE	Administrator		\$ 255,023	Workers' Compensation Insurance	\$ 36,817	IDPH License Fee	\$	
				Unemployment Compensation Insurance	41,824	Advertising: Employee Recruitment	572	
				FICA Taxes	273,754	Health Care Worker Background Check	1,870	
				Employee Health Insurance	25,303	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	4,773	
				401K	230	DUES & SUBSCRIPTIONS	9,855	
				EMPLOYEE BENEFITS-OTHER	69,131	LICENSES	3,851	
				EMPLOYEE PHYSICAL EXAM	302			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 255,023	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 447,361		\$ 17,114		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
BEN KLEIN-MANAGEMENT FEES			\$ 480,000			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 480,000				Seminar Expense	3,620
							ALLOCATION FROM PLATINUM	463
C. Professional Services			Amount	TOTAL			Entertainment Expense	Amount
Vendor/Payee	Type			Description	Line #	Amount	(agree to Sch. V, line 24, col. 8)	Amount
SEE ATTACHED SCHEDULE		\$ 540,464				\$	TOTAL	\$ 4,083
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 540,464	\$				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOOD GLEN NURSING & REHAB CTR

0043935

Report Period Beginning: 1/1/09

Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LTC \$15,339
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? N/A
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,278 Line 10-2
- (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. \$ 113,333
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. \$ 0 Has any meal income been offset against related costs? N/A 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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? _____
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? YES
Attach invoices and a summary of services for all architect and appraisal fees.