

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807 Report Period Beginning: 01/01/01 Ending: 12/31/01

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	412	Intermediate (ICF)	412	150,380	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	412	TOTALS	412	150,380	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	138,675	1,481	2,146	142,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	138,675	1,481	2,146	142,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.63%

D. How many bed-hold days during this year were paid by Public Aid? 5708 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 12/17/1986

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/17/1986 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER # 0031807 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	357,067	60,344	16,753	434,164		434,164		434,164		1
2	Food Purchase		517,692		517,692	(40,515)	477,177	(4,367)	472,810		2
3	Housekeeping	535,010	116,668		651,678		651,678		651,678		3
4	Laundry	52,396	26,953		79,349		79,349		79,349		4
5	Heat and Other Utilities			277,529	277,529		277,529		277,529		5
6	Maintenance	202,412	29,694	412,876	644,982		644,982	(212,174)	432,808		6
7	Other (specify):*										7
8	TOTAL General Services	1,146,885	751,351	707,158	2,605,394	(40,515)	2,564,879	(216,541)	2,348,338		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,480,231	173,772	52,996	2,706,999		2,706,999	(73,684)	2,633,315		10
10a	Therapy			1,733	1,733		1,733		1,733		10a
11	Activities	243,119	11,531	4,892	259,542		259,542		259,542		11
12	Social Services	399,280		21,938	421,218		421,218		421,218		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,122,630	185,303	81,559	3,389,492		3,389,492	(73,684)	3,315,808		16
	C. General Administration										
17	Administrative	300,146		1,199,934	1,500,080		1,500,080	(3,702)	1,496,378		17
18	Directors Fees										18
19	Professional Services			179,183	179,183	(4,855)	174,328	(64,097)	110,231		19
20	Dues, Fees, Subscriptions & Promotions			60,273	60,273		60,273	(21,125)	39,148		20
21	Clerical & General Office Expenses	502,312	21,153	481,928	1,005,393		1,005,393	(391,648)	613,745		21
22	Employee Benefits & Payroll Taxes			850,651	850,651	40,515	891,166		891,166		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,677	2,677		2,677		2,677		24
25	Other Admin. Staff Transportation			4,568	4,568		4,568		4,568		25
26	Insurance-Prop.Liab.Malpractice			76,680	76,680		76,680		76,680		26
27	Other (specify):*										27
28	TOTAL General Administration	802,458	21,153	2,855,894	3,679,505	35,660	3,715,165	(480,572)	3,234,593		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,071,973	957,807	3,644,611	9,674,391	(4,855)	9,669,536	(770,797)	8,898,739		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

LYDIA HEALTHCARE CENTER

#0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							379,903	379,903			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,486	4,486		4,486	554,743	559,229			32
33	Real Estate Taxes			561,469	561,469	4,855	566,324		566,324			33
34	Rent-Facility & Grounds			2,406,080	2,406,080		2,406,080	(2,406,080)				34
35	Rent-Equipment & Vehicles			14,215	14,215		14,215		14,215			35
36	Other (specify):*											36
37	TOTAL Ownership			2,986,250	2,986,250	4,855	2,991,105	(1,471,434)	1,519,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,570	225,570		225,570		225,570			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			225,570	225,570		225,570		225,570			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,071,973	957,807	6,856,431	12,886,211		12,886,211	(2,242,231)	10,643,980			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	OHF 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	(58,871)	30		9
10	Interest and Other Investment Income	(9,703)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	02		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	(9,812)	21		18
19	Entertainment	(4,188)	21		19
20	Contributions	(3,858)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(351,633)	21		24
25	Fund Raising, Advertising and Promotional	(8,062)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(20,500)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(388,768)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (855,449)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,386,782)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,386,782)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,242,231)		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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VA Medical Expenses	\$ (75,435)	10	1
2	Non-allowable Legal Fees	(60,297)	19	2
3	Non-Care Depreciation	(403)	30	3
4	Illness Council of Long Term Care - COPE	(9,205)	20	4
5	Building Company - Amortization of Goodwill	(13,161)	36	5
6	Building Company - Professional Fees	(2,500)	19	6
7	Building Company - Bank Charges	(14)	21	7
8	Discounts Earned	(4,313)	2	8
9	Discounts Earned	(1,142)	21	9
10	Misc. Income	(4,373)	21	10
11	Voided Payroll Checks	(249)	10	11
12	Voided Payroll Checks	(3,702)	17	12
13	Appraisal - Refinancing	(3,800)	19	13
14	Capitalized Repairs & Maintenance	(212,774)	06	14
15				15
16				16
17				17
18				18
19				19
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number LYDIA HEALTHCARE CENTER# 0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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													1
2	Food Purchase	(4,367)											(4,367)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(212,174)											(212,174)	6
7	Other (specify):*													7
8	TOTAL General Services	(216,541)											(216,541)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(73,684)											(73,684)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(73,684)											(73,684)	16
	C. General Administration													
17	Administrative	(3,702)											(3,702)	17
18	Directors Fees													18
19	Professional Services	(66,597)	2,500										(64,097)	19
20	Fees, Subscriptions & Promotions	(21,125)											(21,125)	20
21	Clerical & General Office Expenses	(391,662)	14										(391,648)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(483,086)	2,514										(480,572)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(773,311)	2,514										(770,797)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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	(59,274)	439,177										379,903	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,703)	564,446										554,743	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(2,406,080)										(2,406,080)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(13,161)	13,161											36
37	TOTAL Ownership	(82,138)	(1,389,296)										(1,471,434)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(855,449)	(1,386,782)										(2,242,231)	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
Arnold Simonsen	100%	Winfield Woods	Winfield	Lydia Building		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,406,080	Lydia Building	100.00%	\$	\$ (2,406,080)	1
2	V	33 Real Estate Tax	509,825			509,825		2
3	V	32 Interest - Mortgage				571,319	571,319	3
4	V	32 Interest - Leases				406	406	4
5	V	30 Depreciation				439,177	439,177	5
6	V	36 Amortization - Goodwill				13,161	13,161	6
7	V	19 Professional Fees				2,500	2,500	7
8	V	21 Other - Bank Charges				14	14	8
9	V	32 Interest Income				(7,279)	(7,279)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,915,905			\$ 1,529,123	\$ * (1,386,782)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER # 0031807 Report Period Beginning: 01/01/01 Ending: 12/31/01

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	Arnold Simonsen	Owner	Administrative	100.00%	see attached	30	75.00%	Mgmt Fees	\$ 1,199,934	17-3	1
2	Susan Simonsen	Relative	Administrative	0	see attached	10	25.00%	Salary	91,337	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,291,271		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 LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Chicago		X	Mortgage	\$83,302	11/11/93	\$ 11,000,000	\$ 9,430,821		\$ 571,319	1									
2	Plainsbank		X	Capital Lease	\$600	6/27/98	26,576	0		3.90%	406	2								
3											3									
4											4									
5											5									
Working Capital																				
6	American National Bank			Line of Credit				1,000,000			4,486	6								
7											7									
8											8									
9	TOTAL Facility Related				\$83,902		\$ 11,026,576	\$ 10,430,821		\$ 576,211	9									
B. Non-Facility Related*																				
10	See Supplemental Schedule											10								
11	Interest Income										(9,703)	11								
12	Interest Income (Bldg Co)										(7,279)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$		\$	(16,982)	14								
15	TOTALS (line 9+line14)						\$ 11,026,576	\$ 10,430,821		\$	559,229	15								

* 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

LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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	Name of Lender	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			
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					

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LYDIA HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031807

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home Tax</u>
1. <u>SEE ATTACHED</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>574,868.63</u>	\$ <u>574,868.63</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>574,868.63</u>	\$ <u>574,868.63</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Lydia Healthcare Center
#31807
1/1/01-12/31/01
Real Estate Tax Bills

Tax Index Number	2000 Tax
28-02-429-009-0000	\$ 569,093.16
28-02-429-004-0000	172.86
28-02-429-005-0000	188.96
28-02-429-006-0000	202.82
28-02-429-007-0000	226.41
28-02-429-008-0000	225.28
28-02-411-048-0000	2,124.89
28-02-431-005-0000	170.99
28-02-406-053-0000	91.61
28-02-406-054-0000	91.61
28-02-406-055-0000	91.61
28-02-406-056-0000	91.61
28-02-406-057-0000	91.61
28-02-406-058-0000	90.99
28-02-431-001-0000	190.71
28-02-431-002-0000	167.87
28-02-431-003-0000	167.12
28-02-431-004-0000	162.13
28-02-431-006-0000	190.09
28-02-431-007-0000	189.59
28-02-431-008-0000	172.36
28-02-431-009-0000	167.37
28-02-431-010-0000	174.61
28-02-431-011-0000	168.12
28-02-431-012-0000	164.25
TOTAL	\$ <u>574,868.63</u>

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 132,606 B. General Construction Type: Exterior Frame Brick 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1986</u>	\$ <u>26,179</u>	<u>1</u>
2			<u>various</u>	<u>79,586</u>	<u>2</u>
3	TOTALS			\$ 105,765	3

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1986	\$ 3,939,267	\$ 250,334	35	\$ 112,550	\$ (137,784)	\$ 1,624,369	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1987	211,048		20	11,107	11,107	162,509	9
10	Various		1988	225,278		20	11,855	11,855	160,621	10
11	Various		1989	130,379		20	4,538	4,538	100,113	11
12	Various		1990	55,561		20	2,706	(2,706)	33,495	12
13	Various		1991	72,262		20	3,613	3,613	38,399	13
14	Various		1992	199,474		20	9,974	9,974	62,141	14
15	Various		1993	890,967		20	44,551	44,551	376,733	15
16	Various		1994	168,253		20	8,412	8,412	64,125	16
17	Various		1995	147,370		20	7,371	7,371	47,649	17
18	Various		1996	128,836		20	6,442	6,442	35,916	18
19	Various		1997	198,375		20	9,922	9,922	43,838	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

*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 LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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		\$ 6,367,070	\$ 326,638		\$ 233,041	\$ (93,597)	\$ 2,749,908	1
2	FIRE ALARM RPRS	1998	2,668		20	133	133	532	2
3	NURSE CALL SYS RPRS	1998	1,298		20	65	65	260	3
4	FIRE ALARM RPRS	1998	3,338		20	167	167	626	4
5	SUSPENDED CEILING	1998	2,720		20	136	136	510	5
6	HVAC RPRS	1998	5,602		20	280	280	1,027	6
7	PARKING LOT	1998	4,290		20	215	215	770	7
8	ROOF	1998	35,000		20	1,750	1,750	6,271	8
9	CEILING TILES	1998	524		20	26	26	93	9
10	FIRE ALARM SYS	1998	13,086		20	654	654	2,344	10
11	PAINTING & DECORATING	1998	1,269		20	63	63	226	11
12	HVAC REPAIRS	1998	5,398		20	270	270	945	12
13	CHEM FEED SYS	1998	6,570		20	329	329	1,152	13
14	SIGNS	1998	2,500		20	125	125	438	14
15	ROOF	1998	85,000		20	4,250	4,250	14,875	15
16	FRONT RAMP	1998	950		20	48	48	160	16
17	VENT/HVAC RPRS	1998	9,739		20	487	487	1,623	17
18	DOORS	1998	20,000		20	1,000	1,000	3,417	18
19	PAINTING & DECORATING	1998	25,000		20	1,250	1,250	4,271	19
20	SUSPENDED CEILING	1998	8,000		20	400	400	1,367	20
21	NURSE CALL SYS	1998	1,068		20	53	53	168	21
22	PAINTING & DECOR	1998	(182)		20	(9)	(9)	(30)	22
23	HAND RAIL	1998	454		20	23	23	77	23
24	PAINTING & DECOR	1998	8,237		20	412	412	1,373	24
25	PAINTING & DECOR	1998	2,110		20	106	106	353	25
26	PAINTING & DECOR	1998	(177)		20	(9)	(9)	(29)	26
27	PAINTING & DECOR	1998	683		20	34	34	111	27
28	PAINTING & DECOR	1998	613		20	31	31	101	28
29	TOGGLE SWITCH	1998	654		20	33	33	102	29
30	PAINTING & DECOR	1998	5,941		20	297	297	1,015	30
31	PAINTING & DECOR	1998	13,792		20	690	690	2,358	31
32	PAINTING & DECOR	1998	1,547		20	77	77	263	32
33	PAINTING & DECOR	1998	3,425		20	171	171	584	33
34	TOTAL (lines 1 thru 33)		\$ 6,638,187	\$ 326,638		\$ 246,598	\$ (80,040)	\$ 2,797,261	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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		\$ 6,638,187	\$ 326,638		\$ 246,598	\$ (80,040)	\$ 2,797,261	1
2	PAINTING & DECOR	1998	1,007		20	50	50	171	2
3	PAINTING & DECOR	1998	2,317		20	116	116	396	3
4	PAINTING	1998	1,550		20	78	78	267	4
5	WALLPAPER	1998	250		20	13	13	43	5
6	PVC WALL BUMPER	1998	913		20	46	46	157	6
7	NURSE CALL SYS	1998	627		20	31	31	98	7
8	NURSE CALL SYS	1998	5,810		20	291	291	946	8
9	NEW ROOF	1998	21,043		20	1,052	1,052	3,331	9
10	SWITCHBD RPRS	1998	1,081		20	54	54	167	10
11	ALARM SYS	1998	34,575		20	1,729	1,729	5,619	11
12	SPRINKLER SYS	1998	11,740		20	587	587	1,810	12
13	LAWN SPRINKLER RPRS	1998	581		20	29	29	102	13
14	WATER PUMP RPR	1998	2,240		20	112	112	392	14
15	HVAC REPAIRS	1998	(316)		20	(16)	(16)	(57)	15
16	HVAC REPAIRS	1998	747		20	37	37	133	16
17	TOILET RPRS	1998	1,905		20	95	95	340	17
18	SIGNS	1998	3,020		20	151	151	529	18
19	ALLEY REPAIR	1998	650		20	33	33	110	19
20	TOILET RPRS	1998	1,845		20	92	92	307	20
21	HVAC RPRS	1998	624		20	31	31	98	21
22	CEILING HEATER	1998	992		20	50	50	163	22
23	FLOOR TILE	1999	560		20	28	28	79	23
24	WALLPAPER	1999	5,111		20	256	256	725	24
25	CROWN MOLDING	1999	4,359		20	218	218	618	25
26	CROWN MOLDING	1999	6,452		20	323	323	915	26
27	WALLPAPER	1999	3,591		20	180	180	510	27
28	WALLPAPER	1999	1,210		20	61	61	173	28
29	INSTALL FIRE DAMPERS	1999	51,500		20	2,575	2,575	7,175	29
30	NEW PHONE EXT	1999	905		20	45	45	128	30
31	BOILER-CORR PER CODE	1999	4,000		20	200	200	583	31
32	WALLPAPER	1999	7,848		20	392	392	1,111	32
33	WALLCOVERING	1999	12,210		20	611	611	1,731	33
34	TOTAL (lines 1 thru 33)		\$ 6,829,134	\$ 326,638		\$ 256,148	\$ (70,490)	\$ 2,826,131	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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		\$ 6,829,134	\$ 326,638		\$ 256,148	\$ (70,490)	\$ 2,826,131	1
2	PAINT WALLS	1999	13,162		20	658	658	1,864	2
3	WALLPAPER	1999	5,251		20	263	263	745	3
4	BLINDS	1999	1,206		20	60	60	170	4
5	PAINT WALLS/CHAIR LF	1999	3,580		20	179	179	492	5
6	TOILET	1999	508		20	25	25	67	6
7	PAINT WALL	1999	2,467		20	123	123	349	7
8	PAINT	1999	2,362		20	118	118	334	8
9	PAINT/WALLPAPER	1999	1,070		20	54	54	153	9
10	PAINT/WALLPAPER	1999	1,081		20	54	54	153	10
11	PAINT/WALLPAPER	1999	1,265		20	63	63	179	11
12	PAINT WALLS	1999	747		20	37	37	105	12
13	WALLPAPER	1999	897		20	45	45	128	13
14	WALLPAPER	1999	1,196		20	60	60	170	14
15	PAINT WALLS	1999	805		20	40	40	113	15
16	BLINDS	1999	2,481		20	124	124	351	16
17	WALLPAPER	1999	6,653		20	333	333	944	17
18	CARPET/TILE	1999	3,918		20	196	196	539	18
19	COVE BASE	1999	1,460		20	73	73	201	19
20	PAINT/WALLPAPER	1999	8,135		20	407	407	1,119	20
21	LOCKS	1999	566		20	28	28	75	21
22	CHAIR RAR/COVE BASE	1999	1,113		20	56	56	159	22
23	CARPET	1999	635		20	32	32	88	23
24	WALLPAPER	1999	1,102		20	55	55	151	24
25	VINYL TILE	1999	534		20	27	27	72	25
26	CROWN MOLDING	1999	3,065		20	153	153	395	26
27	CROWN MOLDING	1999	10,465		20	523	523	1,351	27
28	CROWN MOLDING	1999	3,065		20	153	153	395	28
29	CROWN MOLDING	1999	10,465		20	523	523	1,351	29
30	PAINT	1999	507		20	25	25	75	30
31	NURSE CALL SYSTEM	1999	1,630		20	82	82	205	31
32	BOWL DIFFUSER	1999	1,189		20	59	59	152	32
33	LUMBER	1999	599		20	30	30	75	33
34	TOTAL (lines 1 thru 33)		\$ 6,922,313	\$ 326,638		\$ 260,806	\$ (65,832)	\$ 2,838,851	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 12D, Carried Forward		\$ 6,922,313	\$ 326,638		\$ 260,806	\$ (65,832)	\$ 2,838,851	1
2	FIRE DAMPER	1999	250		20	13	13	36	2
3	FLOWERING FLAT	1999	503		20	25	25	65	3
4	ANDERSON LOCK	1999	566		20	28	28	68	4
5	PAINT/WALLPAPER	1999	14,939		20	747	747	1,992	5
6	CROWN MOLDING	1999	3,734		20	187	187	483	6
7	CROWN MOLDING	1999	6,547		20	327	327	845	7
8	CROWN MOLDING	1999	3,625		20	181	181	468	8
9	CROWN MOLDING	1999	6,547		20	327	327	845	9
10	CARPETING	1999	612		20	31	31	78	10
11	WALLPAPER	1999	1,659		20	83	83	208	11
12	PAINT/WALLPAPER	1999	8,137		20	407	407	1,018	12
13	PAINT BORDER	1999	2,467		20	123	123	308	13
14	VINYL WALLCOVERING	1999	9,453		20	473	473	1,183	14
15	BLINDS	1999	1,206		20	60	60	145	15
16	BLINDS	1999	1,206		20	60	60	145	16
17	WALLPAPER	1999	717		20	36	36	87	17
18	CROWN MOLDING	1999	3,065		20	153	153	370	18
19	BORDER PAPER	1999	688		20	34	34	82	19
20	BORDER PAPER	1999	2,475		20	124	124	300	20
21	PAINT WALLS	1999	13,162		20	658	658	1,590	21
22	CROWN MOLDING	1999	10,465		20	523	523	1,264	22
23	HMS	1999	4,465		20	223	223	595	23
24	WALL BUMPER	1999	4,843		20	242	242	545	24
25	WALL PLAQUES SIGN	1999	2,203		20	110	110	248	25
26	WALL PLAQUES SIGN	1999	2,204		20	110	110	248	26
27	WALL PLAQUES SIGN	1999	2,204		20	110	110	248	27
28	WALLPAPER	1999	4,902		20	245	245	551	28
29	WALLPAPER	1999	732		20	37	37	83	29
30	RUBBER COVE BASE	1999	190		20	10	10	23	30
31	WALL BUMPER	1999	4,843		20	242	242	545	31
32	INSTALL DATA CABLE	1999	3,325		20	166	166	374	32
33	VINYL WALLCOVERING	1999	4,876		20	244	244	651	33
34	TOTAL (lines 1 thru 33)		\$ 7,049,123	\$ 326,638		\$ 267,145	\$ (59,493)	\$ 2,854,542	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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		\$ 7,049,123	\$ 326,638		\$ 267,145	\$ (59,493)	\$ 2,854,542	1
2	PAINT WALL/BLINDS	1999	13,559		20	678	678	1,413	2
3	WALLPAPER	1999	6,027		20	301	301	627	3
4	WALL PLAQUES/SIGN	1999	2,204		20	110	110	229	4
5	NTC	1999	38,018		20	1,901	1,901	3,960	5
6	PAVING	1999	5,400		20	270	270	653	6
7	SEXAUER	1999	815		20	41	41	99	7
8	HMS	1999	1,621		20	81	81	176	8
9	HMS	1999	2,386		20	119	119	258	9
10	HMS	1999	7,533		20	377	377	817	10
11	HMS	1999	9,895		20	495	495	1,073	11
12	HMS	1999	12,144		20	607	607	1,315	12
13	DRYWALL	1999	550		20	28	28	56	13
14	DOORSWITCH	1999	634		20	32	32	64	14
15	NURSE CALL SYSTEM	1999	1,006		20	50	50	100	15
16	WOOD CHAIR RAIL	1999	1,113		20	56	56	112	16
17	WATER TREATMENT	1999	5,110		20	256	256	512	17
18	AIR HANDLING UNIT	1999	1,800		20	90	90	180	18
19	WALLPAPER	1999	753		20	38	38	76	19
20	PLUMBING	1999	1,809		20	90	90	180	20
21	SPRINKLER	1999	2,016		20	101	101	202	21
22	PLATE GLASS	1999	550		20	28	28	56	22
23	HVAC REPAIRS	1999	1,787		20	89	89	178	23
24	HVAC REPAIRS	1999	604		20	30	30	60	24
25	FIRE SYSTEM	1999	819		20	41	41	82	25
26	FIRE SYSTEM	1999	505		20	25	25	50	26
27	WALLCOVERING-19909	2000	11,845		20	592	592	1,184	27
28	WALLCOVERING-19910	2000	1,194		20	60	60	120	28
29	WALLCOVERING-19916	2000	4,821		20	241	241	482	29
30	WALLCOVERING-19928	2000	536		20	27	27	54	30
31	WALLCOVERING-19933	2000	2,022		20	101	101	194	31
32	WALLCOVERING-19934	2000	9,329		20	466	466	893	32
33	WALLCOVERING-19935	2000	349		20	17	17	33	33
34	TOTAL (lines 1 thru 33)		\$ 7,197,877	\$ 326,638		\$ 274,583	\$ (52,055)	\$ 2,870,030	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 12F, Carried Forward		\$ 7,197,877	\$ 326,638		\$ 274,583	\$ (52,055)	\$ 2,870,030	1
2	WALLCOVERING-19936	2000	1,986		20	99	99	190	2
3	WALLCOVERING-19937	2000	9,239		20	462	462	886	3
4	WALLCOVERING-19938	2000	392		20	20	20	38	4
5	WALLCOVERING-19947	2000	6,210		20	311	311	596	5
6	WALLCOVERING-19950	2000	9,373		20	469	469	899	6
7	WALLCOVERING-19951	2000	2,300		20	115	115	220	7
8	WALLCOVERING-19952	2000	138		20	7	7	13	8
9	WALLCOVERING-19958	2000	3,099		20	155	155	297	9
10	WALLCOVERING-19959	2000	1,280		20	64	64	117	10
11	WALLCOVERING-19960	2000	1,813		20	91	91	167	11
12	WALLCOVERING-19963	2000	10,143		20	507	507	930	12
13	WALLCOVERING-19976	2000	10,465		20	523	523	959	13
14	WALLCOVERING-19977	2000	1,206		20	60	60	110	14
15	WALLCOVERING-19978	2000	1,206		20	60	60	110	15
16	WALLCOVERING-19979	2000	629		20	31	31	57	16
17	WALLCOVERING-19999	2000	6,653		20	333	333	583	17
18	WALLCOVERING-20003	2000	1,294		20	65	65	114	18
19	WALLCOVERING-19507	2000	396		20	20	20	37	19
20	WALLCOVERING-20004	2000	259		20	13	13	23	20
21	WALLCOVERING-19998	2000	3,506		20	175	175	292	21
22	PAVING - 101234	2000	12,622		20	631	631	1,052	22
23	WALLCOVERING-20024	2000	7,533		20	377	377	597	23
24	WALLCOVERING-20025	2000	2,386		20	119	119	188	24
25	WALLCOVERING-20035	2000	12,500		20	625	625	990	25
26	WALLCOVERING-20073	2000	58		20	3	3	5	26
27	WALLCOVERING-20074	2000	920		20	46	46	69	27
28	WALLCOVERING-20075	2000	7,120		20	356	356	534	28
29	WALLCOVERING-20076	2000	13,363		20	668	668	1,002	29
30	WALLCOVERING-20077	2000	1,194		20	60	60	90	30
31	WALLCOVERING-20078	2000	12,297		20	615	615	923	31
32	WALLCOVERING-20079	2000	12,297		20	615	615	923	32
33	WATER HEATER	2000	6,850		20	343	343	515	33
34	TOTAL (lines 1 thru 33)		\$ 7,358,604	\$ 326,638		\$ 282,621	\$ (44,017)	\$ 2,883,556	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 12G, Carried Forward		\$ 7,358,604	\$ 326,638		\$ 282,621	\$ (44,017)	\$ 2,883,556	1
2	WALLCOVERING-20126	2000	4,688		20	234	234	293	2
3	WALLCOVERING-20127	2000	984		20	49	49	61	3
4	WALLCOVERING-20128	2000	2,263		20	113	113	141	4
5	WALLCOVERING-20139	2000	9,488		20	474	474	593	5
6	WALLCOVERING-20140	2000	9,488		20	474	474	593	6
7	WALLCOVERING-20143	2000	9,470		20	474	474	593	7
8	WALLCOVERING-20162	2000	1,532		20	77	77	96	8
9	WALLCOVERING-20032A	2000	4,589		20	229	229	286	9
10	WALLCOVERING-20089	2000	6,221		20	311	311	389	10
11	WALLCOVERING-200100	2000	4,589		20	229	229	286	11
12	WALLCOVERING-20168	2000	10,971		20	549	549	686	12
13	WALLCOVERING-20169	2000	350		20	18	18	23	13
14	WALLCOVERING-20193	2000	12,506		20	625	625	729	14
15	WALLCOVERING-19891	2000	3,734		20	187	187	203	15
16	WALLCOVERING-19892	2000	6,547		20	327	327	354	16
17	WALLCOVERING-19893	2000	3,734		20	187	187	203	17
18	WALLCOVERING-19894	2000	6,547		20	327	327	354	18
19	NEW DOORS	2000	8,287		20	414	414	794	19
20	BOOSTER HEATER	2000	1,840		20	92	92	169	20
21	DOOR LOCKS	2000	577		20	29	29	56	21
22	LIGHTING FIXTURE COV	2000	874		20	44	44	84	22
23	SOUND SYSTEM	2000	965		20	48	48	92	23
24	TILE	2000	900		20	45	45	71	24
25	4 WATERFLOW"	2000	635		20	32	32	53	25
26	FIRE ALARM	2000	502		20	25	25	40	26
27	HEATER INSTALL	2000	1,945		20	97	97	178	27
28	TOILET	2000	871		20	44	44	73	28
29	DOOR LOCK	2000	574		20	29	29	41	29
30	FENCE & GATE	2000	995		20	50	50	75	30
31	FIRE ALARM	2000	537		20	27	27	38	31
32	SOLENOID	2000	860		20	43	43	61	32
33	FLOORING	2000	582		20	29	29	39	33
34	TOTAL (lines 1 thru 33)		\$ 7,477,249	\$ 326,638		\$ 288,553	\$ (38,085)	\$ 2,891,303	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 12H, Carried Forward		\$ 7,477,249	\$ 326,638		\$ 288,553	\$ (38,085)	\$ 2,891,303	1
2	MAXITROL VALUE	2000	999		20	50	50	67	2
3	UNIT HEATER MOTOR	2000	795		20	40	40	43	3
4	HEATER MOTOR	2000	878		20	43	43	47	4
5	ALARM SYSTEM	2000	2,203		20	110	110	220	5
6	BLINDS	2000	1,551		20	78	78	91	6
7	CLOSED CIRCUIT	2000	4,057		20	203	203	254	7
8	HMS BLINDS	2000	4,135		20	207	207	276	8
9	WALLCOVERING-20141	2000	2,530		20	127	127	159	9
10	9TH FLOOR RENOVATION	2000	29,156		20	1,458	1,458	2,066	10
11	R & W HEATING	2000	1,130		20	57	57	81	11
12	DRAPERIES	2000	5,500		20	275	275	390	12
13	9TH FLOOR RENOVATION	2000	32,896		20	1,645	1,645	2,605	13
14	R & W HEATING	2000	5,650		20	283	283	495	14
15	SIGMA	2000	33,000		20	1,650	1,650	2,888	15
16	9TH FLOOR	2000	30,000		20	1,500	1,500	2,625	16
17	FLOORING	2000	4,525		20	226	226	301	17
18	AIR CONDITIONER	2000	1,059		20	53	53	71	18
19	PHOTO CELL	2000	2,352		20	118	118	216	19
20	SIGN	2000	2,424		20	121	121	121	20
21	SIGN	2000	2,424		20	121	121	121	21
22	WALLCOVERINGS	2001	6,534		20	218	218	218	22
23	LABOR-LOUNGE	2001	6,325		20	211	211	211	23
24	CARPET,COVE BASE	2001	3,264		20	109	109	109	24
25	CARPET REMODEL INSTA	2001	1,578		20	53	53	53	25
26	WALLPAPER & BORDER	2001	479		20	16	16	16	26
27	CABINETRY	2001	26,647		20	888	888	888	27
28	CABINETRY	2001	18,281		20	609	609	609	28
29	COVE BASE CABINETRY	2001	1,965		20	65	65	65	29
30	LABOR-BEAUTYSHOP INS	2001	1,535		20	51	51	51	30
31	COVE BASE VC TILE	2001	8,855		20	295	295	295	31
32	STAFF LOUNGE INSTALL	2001	4,560		20	152	152	152	32
33	SINKS,TOILETS	2001	44,928		20	1,685	1,685	1,685	33
34	TOTAL (lines 1 thru 33)		\$ 7,769,464	\$ 326,638		\$ 301,270	\$ (25,368)	\$ 2,908,792	34

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

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 121, Carried Forward		\$ 7,769,464	\$ 326,638		\$ 301,270	\$ (25,368)	\$ 2,908,792	1
2	INSTALL-STAFF LOUNGE	2001	3,856		20	113	113	113	2
3	PAINT	2001	7,102		20	178	178	178	3
4	INSTALL PICTURE&PAIN	2001	719		20	18	18	18	4
5	8TH & 9TH FLR.REHAB	2001	75,000		20	1,875	1,875	1,875	5
6	MINI BLINDS	2001	5,873		20	74	74	74	6
7	FLAG POLE	2001	2,238		20	19	19	19	7
8	MD CYLINDER	2001	838		20	42	42	42	8
9	LIGHTING	2001	901		20	41	41	41	9
10	FLOOR INSTALL	2001	546		20	18	18	18	10
11	CYLINDER	2001	532		20	20	20	20	11
12	CIRCUIT PANELS INST.	2001	725		20	24	24	24	12
13	FOOD SERVICE	2001	599		20	20	20	20	13
14	LOCKS	2001	578		20	17	17	17	14
15	FIXTURE	2001	707		20	23	23	23	15
16	MATERIAL & LABOR	2001	2,589		20	118	118	118	16
17	WALL PREP & PAINTING	2001	1,880		20	94	94	94	17
18	LUMBER	2001	1,028		20	43	43	43	18
19	CUSTOM DIFFUSER	2001	1,935		20	81	81	81	19
20	LUMBER	2001	1,022		20	26	26	26	20
21	PUMP MOTOR	2001	1,088		20	32	32	32	21
22	MOTOR	2001	1,863		20	31	31	31	22
23	WIRE & AMP FUSES	2001	2,797		20	47	47	47	23
24	LABOR & TRANS EXPENS	2001	1,306		20	22	22	22	24
25	CONSTRUCTION 8th & 9th FLOOR	2001	39,560		20	165	165	165	25
26	MINI BLINDS	2001	17,552		20	146	146	146	26
27	REPAIR & MAINTENANCE	2001	11,877		20	99	99	99	27
28	CUSTOM DIFFUSER	2001	1,505		20	13	13	13	28
29	WIRING	2001	2,171		20	73	73	73	29
30	CONSTRUCTION 9TH FLO	2001	31,050		20	129	129	129	30
31	CONSTRUCTION 9TH FLO	2001	31,050		20	129	129	129	31
32	ELECTRICAL WORK	2001	3,617		20	181	181	181	32
33	LOCKS & DOOR SYSTEM	2001	570		20	10	10	10	33
34	TOTAL (lines 1 thru 33)		\$ 8,024,138	\$ 326,638		\$ 305,191	\$ (21,447)	\$ 2,912,713	34

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

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 12J, Carried Forward		\$ 8,024,138	\$ 326,638		\$ 305,191	\$ (21,447)	\$ 2,912,713	1
2	LABOR FOR CORRIDORS	2001	2,070		20	104	104	104	2
3	SINK,FAUCET	2001	1,125		20	28	28	28	3
4	SINK & FAUCET	2001	1,828		20	68	68	68	4
5	GAS VALVE	2001	836		20				5
6	SPRINKLER REPAIRS	2001	1,093		20	55	55	55	6
7	WIRING	2001	2,978		20	99	99	99	7
8	CABINETRY	2001	4,350		20	18	18	18	8
9	CABINETRY	2001	4,350		20	18	18	18	9
10	CABINETRY	2001	4,350		20	18	18	18	10
11	CABINETRY	2001	8,714		20	36	36	36	11
12	ELEVATOR	2001	1,054		20	31	31	31	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)		\$ 8,056,886	\$ 326,638		\$ 305,666	\$ (20,972)	\$ 2,913,188	34

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

Facility Name & ID Number **LYDIA HEALTHCARE CENTER**

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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-REP, Line 70 for total

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$	\$	\$	\$	\$	70

**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	\$ 609,585	\$ 81,568	\$ 59,471	\$ (22,097)	10	\$ 303,084	71
72	Current Year Purchases	75,531	22,255	5,517	(16,738)	10	5,517	72
73	Fully Depreciated Assets	480,897	2,988	2,988		10	480,897	73
74								74
75	TOTALS	\$ 1,166,013	\$ 106,811	\$ 67,976	\$ (38,835)		\$ 789,498	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	Facility Business	95 PLYMOUTH VOYAGER	1995	\$ 18,461	\$ 1,775	\$	\$ (1,775)	5	\$ 18,461	76
77	Facility Business	1997 VEHICLE	1996	33,528	1,775	3,353	1,578	5	16,765	77
78	Facility Business	CHEVY TRUCK	1998	29,076	1,775	2,908	1,133	5	11,884	78
79										79
80	TOTALS			\$ 81,065	\$ 5,325	\$ 6,261	\$ 936		\$ 47,110	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)	\$ 9,409,729 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,774 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 379,903 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,871) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,749,796 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	1989 FORD VAN - 1996	\$ 7,000	\$ 403	\$ 7,000	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 7,000	\$ 403	\$ 7,000	91

G. Construction-in-Progress

	Description	Cost	
92	Flooring	\$ 30,000	92
93			93
94			94
95		\$ 30,000	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: N/A

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 Date of Lease	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: \$ 12,294 Description: See 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	Social Service staff	1997 Chevy Lumina	\$ 385	\$ 1,922	17
18					18
19					19
20					20
21	TOTAL		\$ 385	\$ 1,922	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. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED AIDES 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 AIDE _____</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 AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 787,260	\$ 787,260	1
2	Cash-Patient Deposits	27,724	27,724	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,997,833	3,407,823	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,735	5,735	6
7	Other Prepaid Expenses	35,000	35,000	7
8	Accounts Receivable (owners or related parties)	3,239,956	3,771,812	8
9	Other(specify): See supplemental schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,093,508	\$ 8,035,354	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,765	13
14	Buildings, at Historical Cost		6,871,530	14
15	Leasehold Improvements, at Historical Cost		2,701,409	15
16	Equipment, at Historical Cost		1,623,696	16
17	Accumulated Depreciation (book methods)		(5,626,163)	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): See supplemental schedule		111,466	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 5,787,703	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,093,508	\$ 13,823,057	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,023,080	\$ 2,023,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,239	40,239	28
29	Short-Term Notes Payable	1,000,000	1,000,000	29
30	Accrued Salaries Payable	274,125	274,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,002	4,002	31
32	Accrued Real Estate Taxes(Sch.IX-B)		632,400	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	60,793	60,793	35
	Other Current Liabilities(specify):			
36	See supplemental schedule		3,227,441	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,402,239	\$ 7,262,080	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,430,821	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,430,821	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,402,239	\$ 16,692,901	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,691,269	\$ (2,869,844)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,093,508	\$ 13,823,057	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,956,727	1
2	Restatements (describe):		2
3	Change in Withdrawals, after 2000 cost report preparation	(900,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,056,727	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,529,542	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	(2,895,000)	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)	\$ (1,365,458)	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)	\$ 3,691,269	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	\$ 14,340,627	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,340,627	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,703	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,703	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	65,423	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 65,423	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,415,753	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,605,394	31
32	Health Care	3,389,492	32
33	General Administration	3,679,505	33
B. Capital Expense			
34	Ownership	2,986,250	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	225,570	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,886,211	40
41	Income before Income Taxes (line 30 minus line 40)**	1,529,542	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,529,542	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** 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 LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning:

01/01/01

Ending:

12/31/01

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	2,096	2,418	\$ 81,509	\$ 33.71	1
2	Assistant Director of Nursing	5,089	5,899	124,658	21.13	2
3	Registered Nurses	3,831	4,044	75,114	18.57	3
4	Licensed Practical Nurses	61,452	66,732	1,107,144	16.59	4
5	Nurse Aides & Orderlies	118,849	125,718	1,056,742	8.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	24,822	27,609	243,119	8.81	10
11	Social Service Workers	28,013	30,460	399,280	13.11	11
12	Dietician					12
13	Food Service Supervisor	2,598	2,952	48,980	16.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,885	43,440	308,087	7.09	15
16	Dishwashers					16
17	Maintenance Workers	15,904	17,256	202,412	11.73	17
18	Housekeepers	69,746	73,539	535,010	7.28	18
19	Laundry	6,449	7,095	52,396	7.38	19
20	Administrator	1,782	2,080	92,146	44.30	20
21	Assistant Administrator	1,271	1,483	42,633	28.75	21
22	Other Administrative	1,782	2,080	165,367	79.50	22
23	Office Manager					23
24	Clerical	32,088	39,655	502,312	12.67	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	1,934	2,080	35,064	16.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	419,591	454,540	\$ 5,071,973 *	\$ 11.16	34

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	419	\$ 16,753	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,800	10-03	39
40	Physical Therapy Consultant	32	1,733	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	245	4,892	11-03	44
45	Social Service Consultant	731	21,938	12-03	45
46	Other(specify)				46
47	Dental	monthly	2,475	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,426	\$ 49,591		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	Nurse Aides	2,564	48,721	10-03	52
53	TOTAL (lines 50 - 52)	2,564	\$ 48,721		53

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

** See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY1998	6 FY1999	7 FY2000	8 FY2001	9 FY2002	10 FY2003	11 FY2004	12 FY2005	13 FY2006
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number LYDIA HEALTHCARE CENTER

0031807

Report Period Beginning: 01/01/01

Ending: 12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC \$22784
- (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? _____
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 225,570
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 40,515 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? none
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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