

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0011593

Facility Name: Mendota Lutheran Home

Address: 500 Sixth Street Mendota 61342
 Number City Zip Code

County: LaSalle

Telephone Number: (815)-539-7439 **Fax #** (815) 538-3400

HFS ID Number: 362212706001

Date of Initial License for Current Owners: 1952

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 © 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Chris S. Csermus **Telephone Number:** (815) 539-7439 Ext 241

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Chris S Csermus

(Title) Administrator

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Carrie E. Echols, CPA
President

(Firm Name & Address) Echols & Associates, PC
609 Main Street Suite A

(Telephone) (815) 539-5666 Fax # 815 539-5665

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

Facility Name & ID Number Mendota Lutheran Home# 0011593 Report Period Beginning: 1/1/2007 Ending: #####

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>71</u>	Intermediate (ICF)	<u>71</u>	<u>25,915</u>	3
4		Intermediate/DD			4
5	<u>14</u>	Sheltered Care (SC)	<u>14</u>	<u>5,110</u>	5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,720</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>800</u>	<u>2,663</u>		<u>3,463</u>	8
9	SNF/PED					9
10	ICF	<u>15,804</u>	<u>13,952</u>		<u>29,756</u>	10
11	ICF/DD					11
12	SC	<u>0</u>	<u>1,810</u>		<u>1,810</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,604</u>	<u>18,425</u>		<u>35,029</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.98%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

NoneF. 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 12/02/1953

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 15 and days of care provided 3,463Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	283,238	43,221	6,459	332,918		332,918		332,918		1
2	Food Purchase		329,641		329,641		329,641	(11,866)	317,775		2
3	Housekeeping	116,896	31,101		147,997		147,997		147,997		3
4	Laundry	75,087	14,019		89,106		89,106		89,106		4
5	Heat and Other Utilities			155,099	155,099		155,099		155,099		5
6	Maintenance	63,861	23,824	8,365	96,050		96,050		96,050		6
7	Other (specify):*										7
8	TOTAL General Services	539,082	441,806	169,923	1,150,811		1,150,811	(11,866)	1,138,945		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,464,847	54,253	378,828	2,897,928		2,897,928		2,897,928		10
10a	Therapy										10a
11	Activities	82,452	5,391	3,548	91,391		91,391		91,391		11
12	Social Services	68,675		2,156	70,831		70,831		70,831		12
13	CNA Training		11,550		11,550		11,550	(15,165)	(3,615)		13
14	Program Transportation		4,485		4,485		4,485	(1,807)	2,678		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,615,974	75,679	384,532	3,076,185		3,076,185	(16,972)	3,059,213		16
	C. General Administration										
17	Administrative	77,425		70,134	147,559		147,559		147,559		17
18	Directors Fees										18
19	Professional Services			53,996	53,996		53,996		53,996		19
20	Dues, Fees, Subscriptions & Promotions			55,365	55,365		55,365	(28,414)	26,951		20
21	Clerical & General Office Expenses	200,545	17,845	12,681	231,071		231,071		231,071		21
22	Employee Benefits & Payroll Taxes			809,726	809,726		809,726		809,726		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,336	3,336		3,336		3,336		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			124,726	124,726		124,726	(240)	124,486		26
27	Other (specify):*			7,777	7,777		7,777	(4,174)	3,603		27
28	TOTAL General Administration	277,970	17,845	1,137,741	1,433,556		1,433,556	(32,828)	1,400,728		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,433,026	535,330	1,692,196	5,660,552		5,660,552	(61,666)	5,598,886		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 Mendota Lutheran Home #0011593 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			230,958	230,958	230,958	(2,195)	228,763				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,381	9,381	9,381		9,381				32
33	Real Estate Taxes			4,717	4,717	4,717	(4,717)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,645	10,645	10,645		10,645				35
36	Other (specify):*											36
37	TOTAL Ownership			255,701	255,701	255,701	(6,912)	248,789				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			488,062	488,062	488,062		488,062				39
40	Barber and Beauty Shops		18,885		18,885	18,885	(18,885)					40
41	Coffee and Gift Shops		1,683		1,683	1,683	(1,683)					41
42	Provider Participation Fee			62,314	62,314	62,314		62,314				42
43	Other (specify):*			38,376	38,376	38,376		38,376				43
44	TOTAL Special Cost Centers		20,568	588,752	609,320	609,320	(20,568)	588,752				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,433,026	555,898	2,536,649	6,525,573	6,525,573	(89,146)	6,436,427				45

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,866)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,414)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(15,165)	13		27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(33,701)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,146)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (89,146)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Mendota Lutheran Home

ID# 0011593

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Rental Utilities	\$ 0	5 1
2	Rental Repairs/mgmt	0	6 2
3	Rental Insurance	(240)	26 3
4	Rental Depreciation	(1,931)	30 4
5	Rental Prop Taxes	(4,717)	33 5
6	Reim Van Usage	(1,807)	14 6
7	Reim Copy fees	0	21 7
8	Barber/Beauty Shop	(18,885)	40 8
9	Gift Shop	(1,683)	41 9
10	Bequest Expense	(3,674)	27 10
11	Non care asset Depr	(264)	30 11
12	Wellspring	(500)	27 12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(33,701)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,866)	0	0	0	0	0	0	0	0	0	0	(11,866)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,866)	0	0	0	0	0	0	0	0	0	0	(11,866)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(15,165)	0	0	0	0	0	0	0	0	0	0	(15,165)	13
14	Program Transportation	(1,807)	0	0	0	0	0	0	0	0	0	0	(1,807)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(16,972)	0	0	0	0	0	0	0	0	0	0	(16,972)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(28,414)	0	0	0	0	0	0	0	0	0	0	(28,414)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(240)	0	0	0	0	0	0	0	0	0	0	(240)	26
27	Other (specify):*	(4,174)	0	0	0	0	0	0	0	0	0	0	(4,174)	27
28	TOTAL General Administration	(32,828)	0	0	0	0	0	0	0	0	0	0	(32,828)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,666)	0	0	0	0	0	0	0	0	0	0	(61,666)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07 Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,195)	0	0	0	0	0	0	0	0	0	0	(2,195)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(4,717)	0	0	0	0	0	0	0	0	0	0	(4,717)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,912)	0	(6,912)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(18,885)	0	0	0	0	0	0	0	0	0	0	(18,885)	40
41	Coffee and Gift Shops	(1,683)	0	0	0	0	0	0	0	0	0	0	(1,683)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(20,568)	0	(20,568)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(89,146)	0	(89,146)	45									

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Mendota Lutheran Home

#

0011593

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 1/1/2007

Ending: #####

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

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Edward Jones		X	Operations	none	2/15/07	547,336	437,735	2/15/08	7.7500	9,381	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 547,336	\$ 437,735			\$ 9,381	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 547,336	\$ 437,735			\$ 9,381	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # 27

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 4,329	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 4,663	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 334	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 4,383	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 4,717	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	3,946	8
	2003	3,829	9
	2004	3,987	10
	2005	4,098	11
	2006	4,663	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mendota Lutheran Home COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0011593

CONTACT PERSON REGARDING THIS REPORT Chris Csernus

TELEPHONE (815) 539-7439 FAX #: (815) 538-3400

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-33-232-021</u>	<u>Rental House amd Lot</u>	\$ <u>4,170.90</u>	\$ _____
2. <u>ENS-110-30</u>	<u>Oil Well (gifted to home in bequest)</u>	\$ <u>492.02</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,662.92</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? X YES _____ 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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Mendota Lutheran Home

0011593 Report Period Beginning:

1/1/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,665 B. General Construction Type: Exterior Brick Frame Brick & Steel Number of Stories One Story

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Building Site</u>	<u>63,000</u>	<u>1951-1975</u>	<u>\$ 82,752</u>	1
2	<u>Building Site</u>	<u>53,760</u>	<u>1993</u>	<u>348,949</u>	2
3	TOTALS	116,760		\$ 431,701	3

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	14		1962	1964	\$ 264,584	\$	various	\$	\$	\$ 264,584	4
5	45		1971	1971	472,968		various			472,968	5
6	31		1975	1975	595,519		various			595,519	6
7			1976	1976	280,167		30			284,841	7
8	43		1995	1995	2,607,338	65,712	various	65,712		818,827	8
	Improvement Type**										
9		Building construction - continued from pg 12		183	65,250	2,175	30	2,175		54,375	9
10		Night lights & door alarm		1971	1,244		10			1,244	10
11		Landscaping		1971	6,835		10			6,835	11
12		Bath tub ramp		1972	226		10			226	12
13		North entry alteration		1974	1,207		25			1,207	13
14		Emergency lights		1974	980		10			980	14
15		Emergency lights		1975	626		10			626	15
16		Landscaping		1976	1,086		10			1,086	16
17		Parking lot improvements		1977	3,177		10			3,177	17
18		Sprinkler system		1978	14,160		20			14,160	18
19		Water heater		1984	4,111		15			4,111	19
20		Cove molding		1985	2,457	98	25	98		2,242	20
21		Nure call lights		1985	2,267		15			2,267	21
22		Heating system rev.		1985	11,343		20			11,343	22
23		Examination room		1985	5,869	195	30	195		4,421	23
24		Water heater booster		1985	782		15			782	24
25		Air conditioner / furnace		1986	3,552	100	20	100		3,552	25
26		Water heater		1986	773		15			773	26
27		Replace roof		1987	98,780	4,939	20	4,939		102,073	27
28		Phone system		1987	3,811	171	20	171		3,811	28
29		Cupboards		1987	303	7	20	7		303	29
30		Water heater - kitchen		1988	2,805		15			2,805	30
31		Rebuild elevator		1988	19,831	992	20	992		19,670	31
32		Basement room		1988	529	26	20	26		507	32
33		Egress window		1989	810	31	26	31		575	33
34		Phase monitor		1989	348	17	20	17		319	34
35		Water heater		1989	1,298		16			1,298	35
36		Soffits and gutters		1989	9,890	380	26	380		7,033	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 Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water heaters	1989	\$ 2,681	\$	16	\$	\$	\$ 2,681	37
38	Harris lounge light fixtures	1990	2,089		10			2,089	38
39	Replace roof south unit	1990	33,700	1,685	20	1,685		29,347	39
40	Getz hood	1990	870	44	20	44		784	40
41	Tub room	1990	3,478	116	30	116		2,068	41
42	Code alert system	1990	17,344		15			17,344	42
43	Office electrical wiring	1990	1,283	64	20	64		1,100	43
44	Ceiling in office / lounge	1990	5,181	199	26	199		3,393	44
45	Medication room	1991	18,286	610	30	610		10,366	45
46	Fire alarm system	1991	14,683	734	20	734		12,051	46
47	Doors monitor & nurse call	1991	2,971	198	15	198		3,169	47
48	Water heaters	1991	2,776		15			2,776	48
49	Shower room remodeling	1991	3,362	112	30	112		1,849	49
50	Black top parking lot	1991	3,180	124	15	124		3,304	50
51	Fire door in serving window	1993	3,373	211	16	211		3,286	51
52	Air conditioner compressor	1993	2,482		10			2,482	52
53	Air conditioner compressor	1993	2,072	138	15	138		1,991	53
54	Radiator covers	1993	6,405	320	20	320		4,642	54
55	Parking lot improvements	1994	1,962		10			1,962	55
56	Renovation of south unit	1994	4,551	228	20	228		3,093	56
57	Cross connecting corrections	1994	10,878	544	20	544		7,343	57
58	Parking lot	1994	141,458	9,431	15	9,431		124,171	58
59	Pressure back flow device	1995	5,567	223	25	223		2,859	59
60	South unit - laundry remodeling	1995	9,165	458	20	458		5,638	60
61	Landscaping	1996	2,841	71	10	71		2,912	61
62	Fence - west wing	1996	2,288		8			2,288	62
63	Water heater	1996	1,208	81	15	81		961	63
64	Lights in office	1996	2,632	132	20	132		1,569	64
65	2' water meter - west wing	1996	895	45	20	45		527	65
66	Light fixtures upstairs	1996	1,168	58	20	58		681	66
67	Vent in oxygen storage room	1996	685	46	20	46		533	67
68	Light fixture - dining room	1996	2,919	146	15	146		1,691	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,799,359	\$ 90,861		\$ 90,861	\$	\$ 2,949,490	70

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 4,799,359	\$ 90,861		\$ 90,861	\$	\$ 2,949,490	1
2	Ceiling tile - dining room	1996	982	65	20	65		752	2
3	Lights - rooms & hall center unit	1997	27,704	461	15	461		27,704	3
4	9Zonline heater/air conditioners	1997	6,299	368	10	368		6,299	4
5	Remodel/refurbish rooms & hall	1997	50,949	3,397	10	3,397		34,249	5
6	Fire annunciator panel	1997	2,718	181	15	181		1,827	6
7	Remodel nurses station	1997	13,762	917	15	917		9,174	7
8	Lights - rooms & hall north unit	1997	18,469	1,847	15	1,847		20,008	8
9	Water heater	1997	4,210	281	10	281		2,877	9
10	Remodel refurbish rooms & hall north unit	1997	53,073	3,538	15	3,538		35,677	10
11	Fire annunciator panel	1997	2,717	181	15	181		1,826	11
12	Windows & ceiling tile	1997	3,261	163	15	163		1,712	12
13	Corner guards	1997	473	12	20	12		473	13
14	Landscape garage	1997	200	10	10	10		200	14
15	Handicap sidewalk pad	1997	1,242	83	10	83		863	15
16	Garage for van	1997	19,744	987	15	987		10,283	16
17	Petroleum tank removal	1998	6,656	444	20	444		4,364	17
18	Windows south unit	1998	10,393	1,039	15	1,039		9,873	18
19	Windows & doors center unit	1998	9,632	963	10	963		9,150	19
20	Lights, handrails & carpet	1998	16,378	1,638	10	1,638		15,559	20
21	New roof	1998	151,886	15,189	10	15,189		144,293	21
22	Code alert system	1998	35,360	3,536	10	3,536		33,592	22
23	Smoke alarms	1998	4,718	472	10	472		4,482	23
24	Fire alarm systems upgrade	1998	6,902	690	10	690		6,556	24
25	Air conditioners	1998	6,299	630	10	630		5,984	25
26	Water heater - west wing	1998	4,197	280	15	280		2,659	26
27	Light north unit	1998	4,061	406	10	406		3,858	27
28	Water softner - west wing	1998	6,213	621	10	621		5,902	28
29	Outdoor wiring & installation	1999	10,529	526	20	526		4,650	29
30	Firesafing drywall	1999	27,134	1,809	15	1,809		15,376	30
31	Air conditioners	1999	1,899	190	10	190		1,614	31
32	Computer wiring	1999	2,154	108	20	108		889	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,309,573	\$ 131,893		\$ 131,893	\$	\$ 3,372,215	34

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 5,309,573	\$ 131,893		\$ 131,893	\$	\$ 3,372,215	1
2	Cabinet & Carpentry work	1999	10,239	683	15	683		5,803	2
3	Plumbing campbell lounge	1999	3,287	164	20	164		1,397	3
4	Electrical fixtures campbell lounge	1999	1,014	101	10	101		861	4
5	New drains south unit	2000	3,159	158	20	158		1,185	5
6	Water heater center unit	2000	7,933	793	10	793		5,949	6
7	Water heaters & plumbing	2000	2,141	214	10	214		1,606	7
8	Water valve west wing	2000	1,027	51	20	51		393	8
9	Roof replacement north unit	2001	167,190	8,360	20	8,360		50,854	9
10	Water heater north unit	2001	4,298	430	10	430		2,794	10
11	Replace faucets north unit	2001	3,162	316	10	316		2,055	11
12	Sign	2001	2,010	201	10	201		1,307	12
13	Admin renovation & computer room	2001	2,337	234	10	234		1,519	13
14	Remodeling assisted living area	2001	77,634	3,882	20	3,882		26,386	14
15	Remodeling assisted living area	2001	36,991	3,699	10	3,699		24,044	15
16	Water heater	2001	382	38	10	38		248	16
17	Central wing lounge expansion	2001	56,596	2,830	20	2,830		17,922	17
18	Install ewewash station	2001	1,962	196	30	196		1,078	18
19	Bathroom flooring	2002	2,127	213	10	213		1,170	19
20	Remodeling & repair	2002	4,053	405	10	405		2,229	20
21	Roof top heating / cooling unit	2002	4,445	445	10	445		2,445	21
22	Dirt & seeding	2002	1,000	100	10	100		550	22
23	Water heater	2002	4,505	451	10	451		2,478	23
24	Landscaping	2002	6,822	341	20	341		1,848	24
25	Exenon heating and air conditioning system	2003	2,984	298	10	298		1,342	25
26	Exenon heating and air conditioning system	2003	2,984	298	10	298		1,342	26
27	PIV Supervisory Switch	2004	1,446	145	10	145		507	27
28	Condenser/Air Handler, Expansion Valve	2004	8,606	430	10	430		5,809	28
29	New gas drver	2004	3,414	342	10	342		1,196	29
30	Kronos Payroll System	2004	23,494	4,699	5	4,699		16,446	30
31	Therm Unit Portable Sure Temp & Cover	2004	910	91	10	91		318	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,757,725	\$ 162,501		\$ 162,501	\$	\$ 3,555,296	34

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

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 5,757,725	\$ 162,501		\$ 162,501	\$	\$ 3,555,296	1
2	(2) Recliners	2004	1,350	135	10	135		473	2
3	Water Meter repair chamber assembly labor	2004	1,386	138	10	138		484	3
4	Food Processor, Bowl & Blades	2004	1,253	125	10	125		438	4
5	Garbage Disposal	2004	814	81	10	81		285	5
6	Washer60# 7-Speed FRT/Equip,Del/Machine mover & install	2004	8,918	892	10	892		3,121	6
7	Diagnostics/call charge \$249.00 Hydrosound Model rebuilt	2004	2,739	479	7	479		2,020	7
8	Carpet for breakroom	2005	622	199	5	199		523	8
9	Countertops breakroom	2005	1,209	44	27.5	44		123	9
10	Boilers	2006	57,281	2,063	27.5	2,063		2,757	10
11	Fire Alarm Panel	2006	11,295	411	27.5	411		548	11
12	Carpet	2006	999	143	5	143		214	12
13	Fire Alarm Panel	2006	12,070	439	27.5	439		586	13
14	Labor/Materials fror Wall	2006	2,218	81	27.5	81		148	14
15	Carpet	2006	1,356	271	5	271		407	15
16	Abatement Disposal Asbestos	2006	8,883	592	15	592		839	16
17	Demo, Landfill	2006	15,000	1,000	15	1,000		1,333	17
18	Fire Alarm System	2007	16,767	838	10	838		1,677	18
19	Door Protective Screen	2007	650		10			65	19
20	Door Frame Fire Door	2007	1,240	62	20	62		62	20
21	Fire Alarm System	2007	16,768	838	10	838		1,677	21
22	Building Repairs & Counter Top	2007	14,633	494	20	494		732	22
23	Stein Heating Unit	2007	2,050	16	15	16		137	23
24	Parking Lot Drainage	2007	5,841	227	15	227			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)		\$ 5,943,067	\$ 172,069		\$ 172,069	\$	\$ 3,573,945	34

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

Facility Name & ID Number Mendota Lutheran Home # 0011593 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 628,349	\$ 51,487	\$ 51,487	\$		\$ 435,047	71
72	Current Year Purchases	45,423	5,207	5,207			5,207	72
73	Fully Depreciated Assets	598,336					598,336	73
74								74
75	TOTALS	\$ 1,272,108	\$ 56,694	\$ 56,694	\$		\$ 1,038,590	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	Resident Van	1996 Ford 8 Passenger	1993	\$ 38,350	\$	\$	\$		\$ 38,350	76
77	Resident Van	1998 Dodge Caravan SE	1999	16,593					16,593	77
78										78
79										79
80	TOTALS			\$ 54,943	\$	\$	\$		\$ 54,943	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 7,701,819	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 228,763	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 228,763	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,667,478	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	House & Lot 04/15/90	\$ 55,710	\$ 1,931	\$ 34,115	86
87	Tree of Life 1995	10,561	264	3,276	87
88	Rental House NBV (Land) 01/01/07	17,865			88
89	Purchase & Demolition of House (Land) 0	66,976			89
90					90
91	TOTALS	\$ 151,112	\$ 2,195	\$ 37,391	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 2,833 Description: KYOCERA AND COPYSTAR COPIERS FROM KYOCERA; GE CAPITAL SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>112</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>49</u></p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,987		2,987
3	Classroom Wages (a)		759		759
4	Clinical Wages (b)		325		325
5	In-House Trainer Wages (c)		13,248		13,248
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,453		1,453
9	TOTALS	\$	\$ 18,772	\$	\$ 18,772
10	SUM OF line 9, col. 1 and 2 (e)	\$	18,772		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

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

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

Facility Name & ID Number Mendota Lutheran Home# 0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7
			Units of Service	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Mendota Lutheran Home# 0011593Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 317,340	\$	1
2	Cash-Patient Deposits	1,568		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	544,989		3
4	Supply Inventory (priced at)	53,760		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,919		6
7	Other Prepaid Expenses	3,208		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	12,108		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 935,892	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,898,086		12
13	Land	721,859		13
14	Buildings, at Historical Cost	5,541,917		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,589,155		16
17	Accumulated Depreciation (book methods)	(4,704,869)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,046,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,982,040	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 168,864	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,500		30
31	Accrued Taxes Payable (excluding real estate taxes)	99,237		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,380		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 361,981	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	437,735		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 437,735	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 799,716	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,182,324	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,982,040	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,157,427	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,157,427	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(975,103)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (975,103)	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)	\$ 5,182,324	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mendota Lutheran Home

0011593

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 5,379,375	1
2	Discounts and Allowances for all Levels	(83,797)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,295,578	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	CNA Training Reimbursements	15,165	11
12	Gift and Coffee Shop	3,182	12
13	Barber and Beauty Care	19,493	13
14	Non-Patient Meals	11,866	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)	\$ 49,706	23
D. Non-Operating Revenue			
24	Contributions	55,353	24
25	Interest and Other Investment Income***	142,025	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 197,378	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		7,808	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,550,470	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,150,811	31
32	Health Care	3,076,185	32
33	General Administration	1,433,556	33
B. Capital Expense			
34	Ownership	255,701	34
C. Ancillary Expense			
35	Special Cost Centers	547,006	35
36	Provider Participation Fee	62,314	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,525,573	40
41	Income before Income Taxes (line 30 minus line 40)**	(975,103)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (975,103)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 Mendota Lutheran Home

0011593

Report Period Beginning:

01/01/07

Ending:

12/31/07

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,080	\$ 58,043	\$ 27.91	1
2	Assistant Director of Nursing	1,960	2,080	46,274	22.25	2
3	Registered Nurses	18,110	20,022	460,344	22.99	3
4	Licensed Practical Nurses	17,731	19,046	384,835	20.21	4
5	CNAs & Orderlies	107,188	116,837	1,398,552	11.97	5
6	CNA Trainees	154	154	1,085	7.05	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,122	4,268	56,737	13.29	8
9	Activity Director	1,960	2,080	22,971	11.04	9
10	Activity Assistants	12,913	13,872	105,210	7.58	10
11	Social Service Workers	5,338	5,582	68,675	12.30	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	31,164	14.98	13
14	Head Cook	2,311	2,383	30,244	12.69	14
15	Cook Helpers/Assistants	25,607	28,644	211,516	7.38	15
16	Dishwashers	1,419	1,434	10,314	7.19	16
17	Maintenance Workers	4,455	4,601	63,861	13.88	17
18	Housekeepers	11,836	13,029	116,896	8.97	18
19	Laundry	8,631	9,479	75,087	7.92	19
20	Administrator	1,960	2,080	77,425	37.22	20
21	Assistant Administrator					21
22	Other Administrative	1,960	2,080	46,125	22.18	22
23	Office Manager					23
24	Clerical	13,739	14,853	145,852	9.82	24
25	Vocational Instruction	640	640	13,248	20.70	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplain</u>	444	444	8,568	19.30	33
34	TOTAL (lines 1 - 33)	246,398	267,768	\$ 3,433,026 *	\$ 12.82	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	135	\$ 6,074	line 1 col 3	35
36	Medical Director	240	9,600	line 10 col 3	36
37	Medical Records Consultant	24	1,200	line 10 col 3	37
38	Nurse Consultant	75	520	line 10 col 3	38
39	Pharmacist Consultant		1,721	line 10 col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,469	line 11 col 3	44
45	Social Service Consultant	15	958	line 12 col 3	45
46	Other(specify) <u>Medicare A</u>	115	17,308	line 17 col 3	46
47	<u>Medicare A</u>		1,953	line 19 col 3	47
48	<u>Accounting</u>		34,611	line 17 col 3	48
49	TOTAL (lines 35 - 48)	641	\$ 76,413		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,543	\$ 75,021	line 10 col 3	50
51	Licensed Practical Nurses	2,105	72,696	line 10 col 3	51
52	Certified Nurse Assistants/Aides	6,706	148,115	line 10 col 3	52
53	TOTAL (lines 50 - 52)	10,354	\$ 295,832		53

Facility Name & ID Number Mendota Lutheran Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See schedule
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 20
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,381 Line 10 col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,314
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? X If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,866
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? yes
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? 100
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ none
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Lindgren, Callihan Van Osdal & Co Ltd The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V Line 27 Column 3

Drug testing	2450
Restricted gift expense	3674
Computer expense	99
Communications	1054
Wellspring	500
	<u>7777</u>

Schedule V Line 43 Column 3

Radiology Expense	1889
Ancillary Expenses	11832
Laboratory Expense	24655
	<u>38376</u>

2006 Long Term Care Real Estate Tax Statement B

The Oil Well was gifted to the Mendota Lutheran Home in bequest.

Schedule XVII Income Statement - Section E line 28 - Other Revenue

Offset to expense

Van usage income	Page 3	Line 14	1807
Copy Charges	Page 3	Line 21	20
Vending machine income			1634
Insurance Refund			37
Recycling Proceeds			38
United States Treasury Refund			214
Account receivable adjustments			813
Trivent Financial Deposit			150
Bank Adjustments			3075
Dispenser Refund			20
			<u>7808</u>

Schedule XIII (f) Expenses Relating to Nurse Aid Training

Nurses aides trained at our facility for other homes:

Heritage Manor 1201 1st Ave., Mendota, IL 61342

Item e: The cost of dropouts and completed costs for home trained aides does not agree with Schedule V, line 13 col 8 because the home receives reimbursement from the IDPA for in house training of nurses aides. See schedule XVII for total Nurses Aide training reimbursements of \$ 15,165

IDPH Facility ID Number: 11593 Mendota Lutheran Home Report Period 01/01/07 - 12/31/07

Schedule XII - Rental Costs

Detail of leased equipment

Kyocera Mita Model No. KM 3060
Kyocera Mita Model No. CS 1820
Kyocera Mita Model No. CS 1820
Kyocera Mita Model No. CS 1820
Copy machines are leased from:

Kyocera
GE Capital
PO Box 740441
Atlanta, GA 30374-0441

Monthly Fee is 208.74 for all copiers

Power Chair, Invacare 9000

Chair Leased from:

Medical Products Group, Inc.
PO BOX 764
Dixon, IL 61021

One Payment of 325.00

Schedule XX - General Information

Question 2 - General information

Life Services Network \$ 5,668

Question 12 - Schedule of allocation of salaries refer to Page 26

Schedule XIX - Support Schedules

Travel & Seminar Expense -Page 21 Item G refer to Page 27

B. Administrative Other

Quickcare Financial	4006
Alice Mc Graw	34611
Specialized Medical	19217
Pathway Health Service	12000
Wessels & Pautsch PC	300
	<hr/>
	70134