

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0040212

Facility Name: Krypton

Address: 502 West 8th Street Metropolis 62960
 Number City Zip Code

County: Massac

Telephone Number: (618)524-8996 **Fax #** (618) 833-4993

HFS ID Number: 371298103001

Date of Initial License for Current Owners: 07/21/1993

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" 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: Richard Stroh **Telephone Number:** (618) 833-5070x11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Krypton

0040212 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 5840

	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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,196</u>			<u>5,196</u>
14	TOTALS	<u>5,196</u>			<u>5,196</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.97%

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

75 (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 11/03/84

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

YES Date 11/03/84 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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/06

Ending:

12/31/06**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	30,068	2,027	613	32,708		32,708		32,708			1
2	Food Purchase		37,350		37,350		37,350		37,350			2
3	Housekeeping		5,441	799	6,240		6,240	60	6,300			3
4	Laundry		667		667		667		667			4
5	Heat and Other Utilities			9,147	9,147		9,147	218	9,365			5
6	Maintenance	2,502	3,243	2,257	8,002		8,002	4,709	12,711			6
7	Other (specify):*											7
8	TOTAL General Services	32,570	48,728	12,816	94,114		94,114	4,987	99,101			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	123,127	2,590	350	126,067		126,067	839	126,906			10
10a	Therapy		160	2,415	2,575		2,575		2,575			10a
11	Activities			316	316		316		316			11
12	Social Services	30,912	589	4,304	35,805		35,805	(298)	35,507			12
13	CNA Training	3,015		490	3,505		3,505		3,505			13
14	Program Transportation		2,309	2,983	5,292		5,292	325	5,617			14
15	Other (specify):* DT Income			108,169	108,169		108,169	(108,169)				15
16	TOTAL Health Care and Programs	157,054	5,648	122,627	285,329		285,329	(107,303)	178,026			16
	C. General Administration											
17	Administrative	43,171		4,000	47,171		47,171	4,098	51,269			17
18	Directors Fees							472	472			18
19	Professional Services			22,491	22,491		22,491	(21,525)	966			19
20	Dues, Fees, Subscriptions & Promotions			821	821		821	(62)	759			20
21	Clerical & General Office Expenses		1,949	4,669	6,618		6,618	5,825	12,443			21
22	Employee Benefits & Payroll Taxes			41,791	41,791		41,791	3,705	45,496			22
23	Inservice Training & Education			103	103		103		103			23
24	Travel and Seminar			30	30		30	82	112			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,881	1,881		1,881	142	2,023			26
27	Other (specify):*											27
28	TOTAL General Administration	43,171	1,949	75,786	120,906		120,906	(7,263)	113,643			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	232,795	56,325	211,229	500,349		500,349	(109,579)	390,770			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 Krypton #0040212 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			4,259	4,259		4,259	6,987	11,246			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6	6		6		6			32
33	Real Estate Taxes			4,688	4,688		4,688	99	4,787			33
34	Rent-Facility & Grounds			45,000	45,000		45,000	(44,573)	427			34
35	Rent-Equipment & Vehicles							185	185			35
36	Other (specify):* See Pg 25			1,699	1,699		1,699	(1,699)				36
37	TOTAL Ownership			55,652	55,652		55,652	(39,001)	16,651			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			22,170	22,170		22,170		22,170			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			22,170	22,170		22,170		22,170			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	232,795	56,325	289,051	578,171		578,171	(148,580)	429,591			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 **Krypton**

0040212

Report Period Beginning: **01/01/06**

Ending: **12/31/06**

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	\$ (108,169)	15	\$	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	6,706	30		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	(10)	20		20
21	Owner or Key-Man Insurance	(1,638)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61)	36		24
25	Fund Raising, Advertising and Promotional	(52)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg 5A	(325)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (103,549)		\$	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)	(45,031)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,031)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (148,580)		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

BHF USE ONLY					
48		49		50	51
					52

Krypton

ID# 0040212
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Clothes	\$ (27)	12	1
2	Floral	(271)	12	2
3	Chamber Dues	(27)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(325)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	60	0	0	0	0	0	0	0	0	0	60	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	218	0	0	0	0	0	0	0	0	0	218	5
6	Maintenance	0	287	4,422	0	0	0	0	0	0	0	0	4,709	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	565	4,422	0	0	0	0	0	0	0	0	4,987	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	839	0	0	0	0	0	0	0	0	839	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	(298)	0	0	0	0	0	0	0	0	0	0	(298)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	325	0	0	0	0	0	0	0	0	0	325	14
15	Other (specify):*	(108,169)	0	0	0	0	0	0	0	0	0	0	(108,169)	15
16	TOTAL Health Care and Programs	(108,467)	325	839	0	0	0	0	0	0	0	0	(107,303)	16
	C. General Administration													
17	Administrative	0	0	4,098	0	0	0	0	0	0	0	0	4,098	17
18	Directors Fees	0	472	0	0	0	0	0	0	0	0	0	472	18
19	Professional Services	0	75	(21,600)	0	0	0	0	0	0	0	0	(21,525)	19
20	Fees, Subscriptions & Promotions	(89)	27	0	0	0	0	0	0	0	0	0	(62)	20
21	Clerical & General Office Expenses	0	1,010	4,815	0	0	0	0	0	0	0	0	5,825	21
22	Employee Benefits & Payroll Taxes	0	3,705	0	0	0	0	0	0	0	0	0	3,705	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	82	0	0	0	0	0	0	0	0	0	82	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	142	0	0	0	0	0	0	0	0	0	142	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(89)	5,513	(12,687)	0	0	0	0	0	0	0	0	(7,263)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(108,556)	6,403	(7,426)	0	0	0	0	0	0	0	0	(109,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Krypton

0040212

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	6,706	281	0	0	0	0	0	0	0	0	0	6,987	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	0	99	0	0	0	0	0	0	0	0	0	99	33
34	Rent-Facility & Grounds	0	0	(44,573)	0	0	0	0	0	0	0	0	(44,573)	34
35	Rent-Equipment & Vehicles	0	0	185	0	0	0	0	0	0	0	0	185	35
36	Other (specify):*	(1,699)	0	0	0	0	0	0	0	0	0	0	(1,699)	36
37	TOTAL Ownership	5,007	380	(44,388)	0	(39,001)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(103,549)	6,783	(51,814)	0	(148,580)	45							

Facility Name & ID Number Krypton

0040212

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
Don Pippins	25	Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
Denise Pippins	25	Liberty House	Marion	ILS 4	Metropolis	CILA
James K. Keller	25	Holly Hill & Mulberry Manor	Anna	JR's Centre	Anna	Workshop
Jo Ann Keller	25	Glen Brook	Vienna	kel-Tech Mgmt Co.	Anna	Mgmt. Co.
		Pilot House	Cairo			
		New Way	Anna			

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	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 60	\$ 60	1	
2	V	5 Utilities		kel-Tech Management Co.	25.00%	218	218	2	
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	287	287	3	
4	V	14 Transportation		kel-Tech Management Co.	25.00%	325	325	4	
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	472	472	5	
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	75	75	6	
7	V	20 Dues, Fees, Subscription		kel-Tech Management Co.	25.00%	27	27	7	
8	V	21 Clerical & General Office		kel-Tech Management Co.	25.00%	1,010	1,010	8	
9	V	22 Employee Benefits & Taxes		kel-Tech Management Co.	25.00%	3,705	3,705	9	
10	V	24 Inservice Training		kel-Tech Management Co.	25.00%	82	82	10	
11	V	26 Insurance		kel-Tech Management Co.	25.00%	142	142	11	
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	99	99	12	
13	V	30 Depreciation		kel-Tech Management Co.	25.00%	281	281	13	
14	Total		\$			\$ 6,783	\$ *	6,783	14

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

Facility Name & ID Number Krypton# 0040212Report Period Beginning: 01/01/06Ending: 12/31/06

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	34	Rent	\$	kel-Tech Management Co.	25.00%	\$ 427	\$ 427	15
16	V	35	Equipment Rental		kel-Tech Management Co.	25.00%	185	185	16
17	V	10	Nursing		kel-Tech Management Co.	25.00%	839	839	17
18	V	17	Administration		kel-Tech Management Co.	25.00%	4,098	4,098	18
19	V	21	Clerical		kel-Tech Management Co.	25.00%	4,815	4,815	19
20	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,422	4,422	20
21	V								21
22	V	19	Professional Services	21,600	kel-Tech Management Co.	25.00%		(21,600)	22
23	V	34	Building Lease	45,000	Krypton Land Trust			(45,000)	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			\$ 66,600			\$ 14,786	\$ * (51,814)	39

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

Facility Name & ID Number Krypton # 0040212 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Don Pippins	Owner/Admin	Administrator	25.00	63,816	20	50.00	Administrator	\$ 43,171	17-1	1
2											2
3											3
4											4
5											5
6											6
7	kel-Tech Management Allocation:										7
8	James A. Keller							ADM	4,095		8
9	Diana Alley							Nursing	838		9
10	Jacob Alley							Maintenance	3,146		10
11											11
12											12
13								TOTAL	\$ 51,250		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 Krypton

0040212

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	363,999	12	\$ 1,008	\$ 21,600	\$ 60	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	363,999	12	3,312	21,600	197	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	363,999	12	369	21,600	22	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	363,999	12	498	21,600	30	4
5	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	363,999	12	748	21,600	44	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	363,999	12	292	21,600	17	6
7	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	363,999	12	1,474	21,600	87	7
8	6	REPAIRS BLDG-B	Mgmt Fee Contribution	363,999	12	284	21,600	17	8
9	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	363,999	12	1,536	21,600	91	9
10	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	363,999	12	721	21,600	43	10
11	14	TRANSPORTATION-B	Mgmt Fee Contribution	363,999	12	4,754	21,600	282	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contribution	363,999	12	7,950	21,600	472	12
13	19	CONTRACT SERVICES	Mgmt Fee Contribution	363,999	12	455	21,600	27	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	363,999	12	810	21,600	48	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	363,999	12	452	21,600	27	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	363,999	12	144	21,600	9	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	363,999	12	0	21,600	0	17
18	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	363,999	12	122	21,600	7	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	363,999	12	191	21,600	11	19
20	21	G & A MISC-B	Mgmt Fee Contribution	363,999	12	288	21,600	17	20
21	21	G & A MISC-B:88210 · SUPPLIE	Mgmt Fee Contribution	363,999	12	158	21,600	9	21
22	21	G & A SUPPLIES-B	Mgmt Fee Contribution	363,999	12	7,730	21,600	459	22
23	21	POSTAGE-B	Mgmt Fee Contribution	363,999	12	3,086	21,600	183	23
24	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	363,999	12	891	21,600	53	24
25	TOTALS					\$ 37,273	\$	\$ 2,212	25

Facility Name & ID Number Krypton

0040212

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	TELEPHONE-B	Mgmt Fee Contribution	363,999	12	\$ 2,367	\$ 21,600	\$ 140	1	
2	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	363,999	12	1,641	21,600	97	2	
3	21	UTILITIES-INTERNET	Mgmt Fee Contribution	363,999	12	408	21,600	24	3	
4	22	INS EMP GROUP-B	Mgmt Fee Contribution	363,999	12	40,061	21,600	2,377	4	
5	22	INSURANCE W/C-B	Mgmt Fee Contribution	363,999	12	2,664	21,600	158	5	
6	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	363,999	12	19,708	21,600	1,170	6	
7	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	363,999	12	1,406	21,600	83	7	
8	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	363,999	12	1,145	21,600	68	8	
9	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	363,999	12	1,246	21,600	74	9	
10	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	363,999	12	1,661	21,600	99	10	
11	30	DEPRECIATION	Mgmt Fee Contribution	363,999	12	4,731	21,600	281	11	
12	34	LEASE BLDG-B	Mgmt Fee Contribution	363,999	12	7,200	21,600	427	12	
13	35	LEASE EQUIP-B	Mgmt Fee Contribution	363,999	12	3,110	21,600	185	13	
14	10	Nursing	Mgmt Fee Contribution	363,999	12	14,140	14,140	21,600	839	14
15	17	Administration	Mgmt Fee Contribution	363,999	12	69,058	69,058	21,600	4,098	15
16	21	Clerical	Mgmt Fee Contribution	363,999	12	81,149	81,149	21,600	4,815	16
17	6	Maintenance	Mgmt Fee Contribution	363,999	12	74,519	74,519	21,600	4,422	17
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 326,215	\$ 238,866	\$ 19,357	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										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Krypton COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0040212

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>08-02-260-009</u>	<u>L0018 BK060,Lots 14,15,16&17Addt</u>	\$ <u>4,553.00</u>	\$ <u>4,553.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,553.00</u>	\$ <u>4,553.00</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Krypton

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,800 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Helathcare</u>	<u>37,500</u>	<u>1984</u>	<u>\$ 8,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	37,500		\$ 8,000	3

Facility Name & ID Number Krypton

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1984	1984	\$ 136,550	\$	30	\$ 4,325	\$ 4,325	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet			2003	1,050		7	210	210	1,050	9
10	Economy Barn			2004	1,057		7	106	106	1,057	10
11	Water Heater & Vent			2004	2,109		7	301	301	2,109	11
12	Water Heater			2005	1,733		7	248	248	1,733	12
13	Roof			2005	6,300	420	15	420		630	13
14	Livingroom Carpet			2006	922	922	7	66	(856)	922	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, Line 70 for total

Facility Name & ID Number **Krypton**

0040212

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	\$	149,721	\$	1,342	\$	5,676	\$	4,334	\$	7,501	70

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

Facility Name & ID Number Krypton # 0040212 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 2,246	\$ 550	\$ 321	\$ (229)		\$ 871	71
72	Current Year Purchases	1,561	1,561	156	(1,405)		1,561	72
73	Fully Depreciated Assets	20,917		2,012	2,012		20,917	73
74								74
75	TOTALS	\$ 24,724	\$ 2,111	\$ 2,489	\$ 378		\$ 23,349	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	Healthcare	1997 Ford Mountaineer	1997	\$ 22,030	\$	\$	\$		\$ 22,030	76
77	Healthcare	1998 Van	1998	26,393					26,393	77
78	Healthcare	2001 Chev. Pickup	2001	14,000	806	2,800	1,994		14,000	78
79										79
80	TOTALS			\$ 62,423	\$ 806	\$ 2,800	\$ 1,994		\$ 62,423	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)		\$ 244,868	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 4,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 10,965	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 6,706	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 93,273	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Krypton

0040212

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ none Description: _____

(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. <u>CLASSROOM PORTION:</u></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>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</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				
3	Classroom Wages (a)	156	215		371
4	Clinical Wages (b)	304	418		722
5	In-House Trainer Wages (c)	809	1,113		1,922
6	Transportation				
7	Contractual Payments	245	245		490
8	CNA Competency Tests				
9	TOTALS	\$ 1,514	\$ 1,991	\$	\$ 3,505
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,505			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	3

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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 Krypton# 0040212Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(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	\$ 10,672	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	119,883		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	177		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	62,344		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 193,076	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,171		15
16	Equipment, at Historical Cost	87,144		16
17	Accumulated Depreciation (book methods)	(93,201)		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)	\$ 7,114	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 200,190	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,343		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,950		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,735		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)	\$ 25,927	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,771		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)	\$ 22,771	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,698	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 151,492	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 200,190	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):	130,937	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 130,937	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	20,555	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)	\$ 20,555	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)	\$ 151,492	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Krypton**# **0040212**Report Period Beginning: **01/01/06**Ending: **12/31/06****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	\$ 489,612	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 489,612	3
B. Ancillary Revenue			
4	Day Care	108,169	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 108,169	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	130	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)	\$ 130	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,224	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,224	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Loss on Sale of Assets	(409)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (409)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 598,726	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	94,114	31
32	Health Care	285,329	32
33	General Administration	120,906	33
B. Capital Expense			
34	Ownership	55,652	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	22,170	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 578,171	40
41	Income before Income Taxes (line 30 minus line 40)**	20,555	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 20,555	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** 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 Krypton

0040212

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
2	Assistant Director of Nursing					2
3	Registered Nurses	2,037	2,077	23,106	11.12	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	3,721	3,953	30,912	7.82	11
12	Dietician					12
13	Food Service Supervisor	3,631	3,815	30,068	7.88	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	253	253	2,502	9.89	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,040	1,040	43,171	41.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,047	2,095	36,133	17.25	29
30	Habilitation Aides (DD Homes)	7,981	8,368	66,903	8.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,710	21,601	\$ 232,795 *	\$ 10.78	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	25	\$ 613	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	350	10-3	39
40	Physical Therapy Consultant	2	70	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	560	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	78	4,304	12-3	45
46	Other(specify) <u>ADM Consultant</u>	80	4,000	17-3	46
47	<u>Psychologist</u>	19	1,400	10a-3	47
48	<u>Dental Care</u>	6	385	10-3	48
49	TOTAL (lines 35 - 48)	276	\$ 15,282		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 241 Line 10
- (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. \$ 22,170
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ _____
- (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? No If no, please explain. Not required for this facility
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
 Owners Compensation
 Jan 1, 2006 - Dec 31, 2006

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 110,449	23,871		3,462					43,171		39,945
Denise Pippins	\$ 70,869	26,149	7,500	25,050	12,170						
Diana Alley	\$ 111,497	12,015	36,000	9,600	15,647		24,095	14,140			
Jo Ann Keller	\$ 145,069			18,500	102,575	23,994					
James K. Keller	\$ 32,543			18,000	14,543						
Jacob Alley	\$ 53,045							53,045			
Jake Alley	\$ 37,527		37,527								
James A. Keller	\$ 100,019		20,150					69,058		10,811	
	\$ 661,018	\$ 62,035	\$ 101,178	\$ 74,612	\$ 144,935	\$ 23,994	\$ 24,095	\$ 136,243	\$ 43,171	\$ 10,811	\$ 39,945

Krypton, Inc.
Analysis of Dues, Fees & Subscriptions
Sch. V, Line 20
2006

Resident Fund Surety bond	\$	50
Food Service Cert.		145
Corp. Ann. Report		124
Post Office Box Rent		72
Advertising		52
Contributions		10
Chamber Dues		27
Less:		
Advertising		(52)
Contributions		(10)
Chamber Dues		(27)
Total	\$	<u>391</u>

Krypton, Inc.
Analysis of Sch. V, Line 36, Col. 3
2006

Bad Debt	\$	61
Officer's Life		<u>1,638</u>
Total	\$	<u>1,699</u>

Krypton, Inc.
Reconciliation Sch.XI, Line 83 to Sch. V, Line 30, Col. 8
2006

Schedule XI	\$	10,965
kel-Tech Mgmt Allocation		<u>281</u>
Schedule V, Line 30, Col. 8	\$	<u>11,246</u>

Krypton, Inc.
Reconciliation of Book to Taxable Income
2006

Adjusted book income	\$	20,554
Adjustment for accrual changes 2006		(51,652)
Adjustment for non-deductable expenses		
Officer's Life Insurance		<u>1,638</u>
Taxable income/loss per federal income tax return - Sch K, Line 18	\$	<u>(29,460)</u>
