



Facility Name & ID Number Krypton# 0040212 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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 5856

	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>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</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>5,602</u>			<u>5,602</u>
14	TOTALS	<u>5,602</u>			<u>5,602</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.66%

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

39 (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 &amp; 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

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/08

Ending:

12/31/08**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
	<b>A. General Services</b>										
1	Dietary	26,460	3,175	876	30,511		30,511		30,511		1
2	Food Purchase		40,469		40,469		40,469		40,469		2
3	Housekeeping		3,934		3,934		3,934	62	3,996		3
4	Laundry		1,411		1,411		1,411		1,411		4
5	Heat and Other Utilities			9,821	9,821		9,821	224	10,045		5
6	Maintenance		3,384	5,235	8,619		8,619	4,096	12,715		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	26,460	52,373	15,932	94,765		94,765	4,382	99,147		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	165,526	2,412	1,259	169,197		169,197	849	170,046		10
10a	Therapy		233	2,605	2,838		2,838		2,838		10a
11	Activities			62	62		62		62		11
12	Social Services	19,656	364	4,621	24,641		24,641	(191)	24,450		12
13	CNA Training	12,590		1,470	14,060		14,060		14,060		13
14	Program Transportation		4,748	6,282	11,030		11,030	440	11,470		14
15	Other (specify):* <b>Day Training</b>			144,604	144,604		144,604	(144,604)			15
16	<b>TOTAL Health Care and Programs</b>	197,772	7,757	164,503	370,032		370,032	(143,506)	226,526		16
	<b>C. General Administration</b>										
17	Administrative	8,951			8,951		8,951	4,113	13,064		17
18	Directors Fees							396	396		18
19	Professional Services			25,781	25,781		25,781	(22,753)	3,028		19
20	Dues, Fees, Subscriptions & Promotions			535	535		535	(136)	399		20
21	Clerical & General Office Expenses	2,717	4,068	3,935	10,720		10,720	7,450	18,170		21
22	Employee Benefits & Payroll Taxes			32,325	32,325		32,325	2,838	35,163		22
23	Inservice Training & Education			123	123		123		123		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			1,915	1,915		1,915	193	2,108		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	11,668	4,068	64,614	80,350		80,350	(7,899)	72,451		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	235,900	64,198	245,049	545,147		545,147	(147,023)	398,124		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:

01/01/08

Ending:

12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			23,347	23,347		23,347	(7,140)	16,207			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,796	1,796		1,796	33,569	35,365			32
33	Real Estate Taxes			5,004	5,004		5,004	111	5,115			33
34	Rent-Facility & Grounds			66,000	66,000		66,000	(65,590)	410			34
35	Rent-Equipment & Vehicles							157	157			35
36	Other (specify):* See Pg 25			3,026	3,026		3,026	(3,026)				36
37	<b>TOTAL Ownership</b>			99,173	99,173		99,173	(41,919)	57,254			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			28,603	28,603		28,603		28,603			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			28,603	28,603		28,603		28,603			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	235,900	64,198	372,825	672,923		672,923	(188,942)	483,981			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: **01/01/08**

Ending: **12/31/08**

**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	\$ (144,604)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(540)	22		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	(7,776)	30		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(185)	32		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)	20		20
21	Owner or Key-Man Insurance	(410)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,616)	36		24
25	Fund Raising, Advertising and Promotional	(59)	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 Attached	(263)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (156,473)</b>		<b>\$</b>	<b>30</b>

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	(32,469)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (32,469)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	<b>\$ (188,942)</b>		<b>37</b>

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Krypton

ID# 0040212  
 Report Period Beginning: 01/01/08  
 Ending: 12/31/08

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Chamber Dues	\$ (72)	20	1
2	Personal Items	(36)	12	2
3	Flowers	(155)	12	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	<b>Total</b>	(263)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
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	62	0	0	0	0	0	0	0	0	0	62	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	224	0	0	0	0	0	0	0	0	0	224	5
6	Maintenance	0	210	3,886	0	0	0	0	0	0	0	0	4,096	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	496	3,886	0	0	0	0	0	0	0	0	4,382	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	849	0	0	0	0	0	0	0	0	849	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	(191)	0	0	0	0	0	0	0	0	0	0	(191)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	440	0	0	0	0	0	0	0	0	0	440	14
15	Other (specify):*	(144,604)	0	0	0	0	0	0	0	0	0	0	(144,604)	15
16	<b>TOTAL Health Care and Programs</b>	(144,795)	440	849	0	0	0	0	0	0	0	0	(143,506)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	4,113	0	0	0	0	0	0	0	0	4,113	17
18	Directors Fees	0	396	0	0	0	0	0	0	0	0	0	396	18
19	Professional Services	0	47	(22,800)	0	0	0	0	0	0	0	0	(22,753)	19
20	Fees, Subscriptions & Promotions	(151)	15	0	0	0	0	0	0	0	0	0	(136)	20
21	Clerical & General Office Expenses	0	887	6,563	0	0	0	0	0	0	0	0	7,450	21
22	Employee Benefits & Payroll Taxes	(540)	3,378	0	0	0	0	0	0	0	0	0	2,838	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	193	0	0	0	0	0	0	0	0	0	193	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(691)	4,916	(12,124)	0	0	0	0	0	0	0	0	(7,899)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(145,486)	5,852	(7,389)	0	0	0	0	0	0	0	0	(147,023)	29

STATE OF ILLINOIS

Facility Name & ID Number Krypton

# 0040212

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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	(7,776)	636	0	0	0	0	0	0	0	0	0	(7,140)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(185)	0	33,754	0	0	0	0	0	0	0	0	33,569	32
33	Real Estate Taxes	0	111	0	0	0	0	0	0	0	0	0	111	33
34	Rent-Facility & Grounds	0	410	(66,000)	0	0	0	0	0	0	0	0	(65,590)	34
35	Rent-Equipment & Vehicles	0	0	157	0	0	0	0	0	0	0	0	157	35
36	Other (specify):*	(3,026)	0	0	0	0	0	0	0	0	0	0	(3,026)	36
37	<b>TOTAL Ownership</b>	<b>(10,987)</b>	<b>1,157</b>	<b>(32,089)</b>	<b>0</b>	<b>(41,919)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(156,473)</b>	<b>7,009</b>	<b>(39,478)</b>	<b>0</b>	<b>(188,942)</b>	<b>45</b>							

Facility Name & ID Number Krypton

# 0040212

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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
Jacob Alley	50	Lincoln Square	Jonesboro	ILS 1-3 & 5-6	Anna	CILA
Diana Alley	50	Liberty House	Marion	ILS 4	Metropolis	CILA
		Holly Hill & Mulberry Manor	Anna	JR's Centre	Anna	Workshop
		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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 62	\$ 62 1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	224	224 2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	210	210 3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	440	440 4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	396	396 5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	47	47 6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	15	15 7
8	V	21 Clerical & General		kel-Tech Management Co.	25.00%	887	887 8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,378	3,378 9
10	V	26 Insurance		kel-Tech Management Co.	25.00%	193	193 10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	636	636 11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	111	111 12
13	V	34 Rent		kel-Tech Management Co.	25.00%	410	410 13
14	Total		\$			\$ 7,009	\$ * 7,009 14

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

Facility Name & ID Number Krypton# 0040212Report Period Beginning: 01/01/08Ending: 12/31/08

## 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	35 Equipment Rental	\$	kel-Tech Management Co.	25.00%	\$ 157	\$ 157	15
16	V	10 Nursing		kel-Tech Management Co.	25.00%	849	849	16
17	V	17 Administration		kel-Tech Management Co.	25.00%	4,113	4,113	17
18	V	21 Clerical		kel-Tech Management Co.	25.00%	6,563	6,563	18
19	V	6 Maintenance		kel-Tech Management Co.	25.00%	3,886	3,886	19
20	V							20
21	V	19 Professional Services	22,800	kel-Tech Management Co.	25.00%		(22,800)	21
22	V	34 Lease Payments	66,000	Krypton Land Trust	100.00%		(66,000)	22
23	V	32 Mortgage Interest		Krypton Land Trust	100.00%	33,754	33,754	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		\$ 88,800			\$ 49,322	\$ * (39,478)	39

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

Facility Name & ID Number Krypton # 0040212 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	Jacob Alley	Owner		50.00					\$		1
2	Diana Alley	Owner		50.00	59,054						2
3											3
4	Don Pippins	Admin	Administrator		73,758	4	10.00		8,951	17-1	4
5											5
6											6
7	kel-Tech Management Allocation:										7
8	James A. Keller							ADM	4,113	17-1	8
9	Diana Alley							Nursing	849	10-1	9
10	Jacob Alley							Maintenance	3,886	6-1	10
11											11
12											12
13								TOTAL	\$ 17,799		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: 01/01/08 Ending: 12/31/08

## 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 Management 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	400,583	10	\$ 1,100	\$ 22,800	\$ 63	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	400,583	10	3,573	22,800	203	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	400,583	10	365	22,800	21	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	400,583	10	500	22,800	28	4
5	6	MAINT BUILDING	Mgmt Fee Contribution	400,583	10	67	22,800	4	5
6	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	400,583	10	540	22,800	31	6
7	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	400,583	10	257	22,800	15	7
8	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	400,583	10	1,934	22,800	110	8
9	6	REPAIRS BLDG-B	Mgmt Fee Contribution	400,583	10	(409)	22,800	(23)	9
10	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	400,583	10	796	22,800	45	10
11	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	400,583	10	721	22,800	41	11
12	14	TRANSPORTATION-B	Mgmt Fee Contribution	400,583	10	7,009	22,800	399	12
13	18	DIRECTOR'S FEES	Mgmt Fee Contribution	400,583	10	6,950	22,800	396	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	400,583	10	825	22,800	47	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	400,583	10	272	22,800	15	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	400,583	10	24	22,800	1	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	400,583	10	85	22,800	5	17
18	21	CONTRACT SERVICES-B	Mgmt Fee Contribution	400,583	10	873	22,800	50	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	400,583	10	103	22,800	6	19
20	21	G & A MISC-B	Mgmt Fee Contribution	400,583	10	198	22,800	11	20
21	21	G & A SUPPLIES-B	Mgmt Fee Contribution	400,583	10	6,832	22,800	389	21
22	21	POSTAGE-B	Mgmt Fee Contribution	400,583	10	2,703	22,800	154	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	400,583	10	961	22,800	55	23
24	21	TELEPHONE-B	Mgmt Fee Contribution	400,583	10	1,922	22,800	109	24
25	TOTALS					\$ 38,199	\$	\$ 2,175	25

Facility Name & ID Number Krypton

# 0040212

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 Management 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	CELL PHONE EXPENSE	Mgmt Fee Contribution	400,583	10	\$ 1,478	\$ 22,800	\$ 84	1	
2	21	UTILITIES-INTERNET	Mgmt Fee Contribution	400,583	10	408	22,800	23	2	
3	22	INS EMP GROUP-B	Mgmt Fee Contribution	400,583	10	36,354	22,800	2,069	3	
4	22	INSURANCE W/C-B	Mgmt Fee Contribution	400,583	10	1,051	22,800	60	4	
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	400,583	10	21,940	22,800	1,249	5	
6	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	400,583	10	1,266	22,800	72	6	
7	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	400,583	10	2,117	22,800	120	7	
8	30	DEPRECIATION-B	Mgmt Fee Contribution	400,583	10	11,179	22,800	636	8	
9	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	400,583	10	1,945	22,800	111	9	
10	34	LEASE BLDG-B	Mgmt Fee Contribution	400,583	10	7,200	22,800	410	10	
11	35	LEASE EQUIP-B	Mgmt Fee Contribution	400,583	10	2,757	22,800	157	11	
12	10	Nursing	Mgmt Fee Contribution	400,583	10	14,917	14,917	22,800	849	12
13	17	Administration	Mgmt Fee Contribution	400,583	10	72,258	72,258	22,800	4,113	13
14	21	Clerical	Mgmt Fee Contribution	400,583	10	115,314	115,314	22,800	6,563	14
15	6	Maintenance	Mgmt Fee Contribution	400,583	10	68,277	68,277	22,800	3,886	15
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 358,460	\$ 270,766	\$ 20,402	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Ford Credit		X	Vehicle Loan	\$375.25	6/14/08	\$ 15,868	\$ 13,981	5/14/12	7.1900	\$ 665	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Capaha		X	Line of Credit		3/10/08	100,000		3/10/09	5.0000	1,131	6								
7	Mulberry Manor	X		Operating Capital		3/1/08	100,000	100,000				7								
8												8								
9	<b>TOTAL Facility Related</b>				\$375.25		\$ 215,868	\$ 113,981			\$ 1,796	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 215,868	\$ 113,981			\$ 1,796	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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&amp;17Addt</u>	\$ <u>4,996.84</u>	\$ <u>4,996.84</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>4,996.84</u>	\$ <u>4,996.84</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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).

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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>Healthcare</u>	<u>37,500</u>	<u>1984</u>	<u>\$ 8,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>37,500</b>		<b>\$ 8,000</b>	<b>3</b>

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
	<b>Improvement Type**</b>										
9	Carpet			2003	1,050		7	60	60	1,050	9
10	8X12 Economy Barn			2004	1,057		7	106	106	1,057	10
11	Water Heater			2004	2,109		7	301	301	2,109	11
12	Water Heater			2005	1,733		7	247	247	1,733	12
13	Roof			2005	6,300	420	15	420		1,470	13
14	Livingroom Carpet			2006	922		7	132	132	922	14
15	New Doors			2007	1,588		15				15
16	Bathrooms Remodel			2007	2,816		15				16
17	Painting Walls/Doors/Base Molding			2007	21,335	2,445	15	1,716	(729)	2,892	17
18	Whole House Carpet			2007	29,494	7,223	7	4,215	(3,008)	11,438	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:

**01/01/08**

Ending:

**12/31/08**

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>204,954</b>	\$	<b>10,088</b>	\$	<b>11,522</b>	\$	<b>1,434</b>	\$	<b>22,671</b>	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: 01/01/08 Ending: 12/31/08

## 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	\$ 2,892	\$ 439	\$ 413	\$ (26)		\$ 1,795	71
72	Current Year Purchases	5,530	3,518	335	(3,183)		3,518	72
73	Fully Depreciated Assets	22,478		1,751	1,751		22,478	73
74								74
75	TOTALS	\$ 30,900	\$ 3,957	\$ 2,499	\$ (1,458)		\$ 27,791	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	\$	\$	\$	5	\$ 22,030	76
77	Healthcare	1998 Van	1998	26,393				5	26,393	77
78	Healthcare	2001 Chev. Pickup	2001	14,000				5	14,000	78
79	Healthcare	2008 Ford Focus	2008	15,503	9,302	1,550	(7,752)	5	9,302	79
80	TOTALS			\$ 77,926	\$ 9,302	\$ 1,550	\$ (7,752)		\$ 71,725	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)	\$ 321,780	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,571	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,776)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,187	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: 01/01/08

Ending: 12/31/08

**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	<b>TOTAL</b>				\$			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$	\$	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>44</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>86</u></p>
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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)	276	1,449		1,725
4	Clinical Wages (b)	538	2,826		3,364
5	In-House Trainer Wages (c)	1,200	6,301		7,501
6	Transportation				
7	Contractual Payments	245	1,225		1,470
8	CNA Competency Tests				
9	TOTALS	\$ 2,259	\$ 11,801	\$	\$ 14,060
10	SUM OF line 9, col. 1 and 2 (e)	\$ 14,060			

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	<u>5</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>6</b>

- (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 Krypton# 0040212 Report Period Beginning:01/01/08 Ending:12/31/08

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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: 01/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 134,792	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	38,177		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DSP Training Reimbursable</u>	1,665		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 174,634	\$	10
	<b>B. Long-Term Assets</b>			
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	68,407		15
16	Equipment, at Historical Cost	82,431		16
17	Accumulated Depreciation (book methods)	(95,722)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 55,116	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 229,750	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 53,001	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,420		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,333		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,122		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 67,876	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	113,981		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 113,981	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 181,857	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 47,893	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 229,750	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>140,941</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>140,941</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>13,129</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(106,177)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(93,048)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>47,893</b>	<b>24</b> *

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

Facility Name & ID Number **Krypton**# **0040212**Report Period Beginning: **01/01/08**Ending: **12/31/08****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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 532,519	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 532,519	3
<b>B. Ancillary Revenue</b>			
4	Day Care	144,604	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 144,604	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,050	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,050	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	185	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 185	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>R/E Tax Reimbursement from Prior Stockholders</b>	1,694	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,694	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 686,052	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	94,765	31
32	Health Care	370,032	32
33	General Administration	80,350	33
<b>B. Capital Expense</b>			
34	Ownership	99,173	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	28,603	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 672,923	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	13,129	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 13,129	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:

01/01/08

Ending:

12/31/08

**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	111	111	3,881	34.96	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	2,123	2,287	19,637	8.59	11
12	Dietician	3,022	3,020	26,435	8.75	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	472	471	9,138	19.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	298	298	2,715	9.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	111	111	2,221	20.01	28
29	Resident Services Coordinator	1,966	2,045	41,596	20.34	29
30	Habilitation Aides (DD Homes)	15,150	15,386	130,277	8.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,253	23,729	\$ 235,900 *	\$ 9.94	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	20	\$ 811	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	3	60	10-3	38
39	Pharmacist Consultant	12	390	10-3	39
40	Physical Therapy Consultant	4	140	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	455	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	59	3,242	12-3	45
46	Other(specify) <u>Psychologist</u>	19	1,400	10a-3	46
47	<u>QMRP Consultant</u>	138	1,380	12-3	47
48					48
49	TOTAL (lines 35 - 48)	310	\$ 11,478		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

Facility Name & ID Number Krypton

# 0040212

Report Period Beginning: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Don Pippins</u>	<u>Prior Stockholder</u>		\$ <u>8,951</u>	<u>Workers' Compensation Insurance</u>	\$ <u>5,866</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>4,357</u>	<u>Advertising: Employee Recruitment</u>	_____	
				<u>FICA Taxes</u>	<u>17,882</u>	<u>Health Care Worker Background Check</u>	_____	
				<u>Employee Health Insurance</u>	<u>3,680</u>	(Indicate # of checks performed <u>11</u> )	<u>176</u>	
				<u>Employee Meals</u>	<u>540</u>	<u>Patient Background Checks</u>	_____	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>	_____	<u>Surety Bond/Sam's Club Mem.</u>	<u>85</u>	
						<u>Corp Ann Report</u>	<u>123</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>8,951</u>	<b>Less:</b>		<u>kel-Tech Mgmt Allocation</u>	<u>15</u>	
(List each licensed administrator separately.)				<u>Employee Meals</u>	<u>(540)</u>	<u>Contrib./Chamber Dues/Adv</u>	<u>151</u>	
				<u>kel-Tech Management Allocation</u>	<u>3,378</u>	<b>Less: Contrib./Chamber Dues</b>	<u>(92)</u>	
						<b>Less: Public Relations Expense</b>	( _____ )	
						<u>Non-allowable advertising</u>	<u>(59)</u>	
						<u>Yellow page advertising</u>	( _____ )	
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <u>35,163</u>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <u>399</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ _____	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
							<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	_____
							<u>Seminar Expense</u>	_____
							<u>Entertainment Expense</u>	( _____ )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>25,781</u>	<b>TOTAL</b>		\$ _____	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	\$ _____
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 226 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 X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
0040212 Date: 3/1/08
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 28,603  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? \_\_\_\_\_ 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, 2008 - Dec 31, 2008

	Totals / Entity	Holly Hill	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 82,709	32,400					8,951		41,358
Denise Pippins	\$ 32,493	32,000	493						
Diana Alley	\$ 73,971	21,600	15,435		22,019	14,917			
Jo Ann Keller	\$ 129,702		104,927	24,775					
James K. Keller	\$ 14,877		14,877						
Jacob Alley	\$ 56,048					56,048			
Jake Alley	\$ -								
James A. Keller	\$ 88,866					72,258		16,608	
	\$ 478,666	\$ 86,000	\$ 135,732	\$ 24,775	\$ 22,019	\$ 143,223	\$ 8,951	\$ 16,608	\$ 41,358

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Krypton, Inc.  
Analysis of Sch. V, Line 36, Col. 3  
2008

Bad Debt	\$ 2,616
Officer's Life	<u>410</u>
Total	<u>\$ 3,026</u>

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Krypton, Inc.  
Reconciliation Sch.XI, Line 83 to Sch. V, Line 30, Col. 8  
2008

Schedule XI	\$ 15,571
kel-Tech Mgmt Allocation	<u>636</u>
Schedule V, Line 30, Col. 8	<u>\$ 16,207</u>

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