

Facility Name & ID Number Krypton

0040212 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,318			5,318	13
14	TOTALS	5,318			5,318	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.06%

D. How many bed-hold days during this year were paid by the Department? 37 (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 03/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/2008 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: 12/31/2013 Fiscal Year: 12/31/2013

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		2,241	654	2,895		2,895	(1,294)	1,601		1
2	Food Purchase		49,345		49,345		49,345	(2,136)	47,209		2
3	Housekeeping		7,797	922	8,719		8,719	(2,665)	6,054		3
4	Laundry		667		667		667	(73)	594		4
5	Heat and Other Utilities			16,052	16,052		16,052	(4,974)	11,078		5
6	Maintenance		10,697	7,868	18,565		18,565	642	19,207		6
7	Other (specify):*										7
8	TOTAL General Services		70,747	25,496	96,243		96,243	(10,500)	85,743		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	276,477	3,859	1,671	282,007		282,007	(29,439)	252,568		10
10a	Therapy		892	3,525	4,417		4,417		4,417		10a
11	Activities	31,916		489	32,405		32,405	(98)	32,307		11
12	Social Services		1,414	3,490	4,904		4,904	(604)	4,300		12
13	CNA Training	21,837		1,960	23,797		23,797		23,797		13
14	Program Transportation		10,684	4,018	14,702		14,702	(650)	14,052		14
15	Other (specify):* Day Training Exp.			141,682	141,682		141,682	(141,682)			15
16	TOTAL Health Care and Programs	330,230	16,849	160,435	507,514		507,514	(172,473)	335,041		16
	C. General Administration										
17	Administrative							5,037	5,037		17
18	Directors Fees			300	300		300	(300)			18
19	Professional Services			26,766	26,766		26,766	(25,016)	1,750		19
20	Dues, Fees, Subscriptions & Promotions			2,093	2,093		2,093	(353)	1,740		20
21	Clerical & General Office Expenses	16,115	3,388	6,536	26,039		26,039	6,541	32,580		21
22	Employee Benefits & Payroll Taxes			41,907	41,907		41,907	(2,655)	39,252		22
23	Inservice Training & Education			84	84		84		84		23
24	Travel and Seminar			127	127		127		127		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,121	3,121		3,121	(1,291)	1,830		26
27	Other (specify):* Finance Charge			52	52		52	(52)			27
28	TOTAL General Administration	16,115	3,388	80,986	100,489		100,489	(18,089)	82,400		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	346,345	90,984	266,917	704,246		704,246	(201,062)	503,184		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: 01/01/2013 Ending: 12/31/2013

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	
	D. Ownership											
30	Depreciation			19,062	19,062		19,062	1,822	20,884			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,743	4,743		4,743	30,522	35,265			32
33	Real Estate Taxes			11,674	11,674		11,674	(5,815)	5,859			33
34	Rent-Facility & Grounds			70,924	70,924		70,924	(79,832)	(8,908)			34
35	Rent-Equipment & Vehicles			1,037	1,037		1,037	30	1,067			35
36	Other (specify):* Tax Pen/State Inc. Tax			427	427		427		427			36
37	TOTAL Ownership			107,867	107,867		107,867	(53,273)	54,594			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			31,150	31,150		31,150		31,150			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,150	31,150		31,150		31,150			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	346,345	90,984	405,934	843,263		843,263	(254,335)	588,928			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:

01/01/2013

Ending:

12/31/2013

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	\$ (141,682)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,615)	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				8
9	Non-Straightline Depreciation	1,672	30		9
10	Interest and Other Investment Income	(131)	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	(98)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,096)	19		16
17	Non-Care Related Fees	(300)	18		17
18	Fines and Penalties	(52)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 Pg. 5A	(78,378)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (221,680)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(32,655)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (32,655)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (254,335)		37

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

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

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

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Personal Items/Floral/Gifts	\$ (604)	12	1
2	CILA Fees	(403)	20	2
3	CILA Dietary Expenses	(1,294)	1	3
4	CILA Food Expense	(2,136)	2	4
5	CILA Housekeeping Expense	(2,738)	3	5
6	CILA Laundry Expense	(73)	4	6
7	CILA Utilities Expense	(5,189)	5	7
8	CILA Maintenance Expense	(4,799)	6	8
9	CILA Nursing Expense	(92)	10	9
10	CILA Activities Expense	(98)	11	10
11	CILA Transportation Expense	(1,544)	14	11
12	CILA Office Expenses	(2,011)	21	12
13	CILA Employee Benefits & Payroll Tax Exp.	(4,138)	22	13
14	CILA Insurance Expense	(1,427)	26	14
15	CILA Real Estate Taxes	(5,997)	33	15
16	CILA Lease Expense	(15,423)	34	16
17	CILA Staff Expenses	(30,412)	10	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		(78,378)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(1,294)	0	0	0	0	0	0	0	0	0	0	(1,294)	1
2	Food Purchase	(2,136)	0	0	0	0	0	0	0	0	0	0	(2,136)	2
3	Housekeeping	(2,738)	73	0	0	0	0	0	0	0	0	0	(2,665)	3
4	Laundry	(73)	0	0	0	0	0	0	0	0	0	0	(73)	4
5	Heat and Other Utilities	(5,189)	215	0	0	0	0	0	0	0	0	0	(4,974)	5
6	Maintenance	(4,799)	156	5,285	0	0	0	0	0	0	0	0	642	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,229)	444	5,285	0	0	0	0	0	0	0	0	(10,500)	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	(30,504)	0	1,065	0	0	0	0	0	0	0	0	(29,439)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(98)	0	0	0	0	0	0	0	0	0	0	(98)	11
12	Social Services	(604)	0	0	0	0	0	0	0	0	0	0	(604)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,544)	894	0	0	0	0	0	0	0	0	0	(650)	14
15	Other (specify):*	(141,682)	0	0	0	0	0	0	0	0	0	0	(141,682)	15
16	TOTAL Health Care and Programs	(174,432)	894	1,065	0	0	0	0	0	0	0	0	(172,473)	16
	C. General Administration													
17	Administrative	0	0	5,037	0	0	0	0	0	0	0	0	5,037	17
18	Directors Fees	(300)	0	0	0	0	0	0	0	0	0	0	(300)	18
19	Professional Services	(1,096)	80	(24,000)	0	0	0	0	0	0	0	0	(25,016)	19
20	Fees, Subscriptions & Promotions	(403)	50	0	0	0	0	0	0	0	0	0	(353)	20
21	Clerical & General Office Expenses	(2,011)	1,049	7,503	0	0	0	0	0	0	0	0	6,541	21
22	Employee Benefits & Payroll Taxes	(5,753)	3,098	0	0	0	0	0	0	0	0	0	(2,655)	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	(1,427)	136	0	0	0	0	0	0	0	0	0	(1,291)	26
27	Other (specify):*	(52)	0	0	0	0	0	0	0	0	0	0	(52)	27
28	TOTAL General Administration	(11,042)	4,413	(11,460)	0	0	0	0	0	0	0	0	(18,089)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(201,703)	5,751	(5,110)	0	0	0	0	0	0	0	0	(201,062)	29

STATE OF ILLINOIS

Facility Name & ID Number Krypton# 0040212

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,672	150	0	0	0	0	0	0	0	0	0	1,822	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(229)	0	30,751	0	0	0	0	0	0	0	0	30,522	32
33	Real Estate Taxes	(5,997)	182	0	0	0	0	0	0	0	0	0	(5,815)	33
34	Rent-Facility & Grounds	(15,423)	515	(64,924)	0	0	0	0	0	0	0	0	(79,832)	34
35	Rent-Equipment & Vehicles	0	30	0	0	0	0	0	0	0	0	0	30	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,977)	877	(34,173)	0	0	0	0	0	0	0	0	(53,273)	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)	(221,680)	6,628	(39,283)	0	0	0	0	0	0	0	0	(254,335)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacob L. Alley	30	Mulberry Manor	Anna	Pilot House of Cairo	Cairo	CILA
Diana Alley	30	Glen Brook of Vienna	Vienna	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
Joshua Alley	20	Krypton ICF-DD	Metropolis	ILS 2, 5-8	Anna	CILA
Jacob L. Alley, II	20			ILS 4	Metropolis	CILA
				Krypton CILA	CILA	Metropolis

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 Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 73	\$	73	1
2	V	5 Heat & Other Utilities		kel-Tech Management Co.	25.00%	215		215	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	156		156	3
4	V	14 Program Transportation		kel-Tech Management Co.	25.00%	894		894	4
5	V	19 Professional Services		kel-Tech Management Co.	25.00%	80		80	5
6	V	20 Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	50		50	6
7	V	21 Clerical & General		kel-Tech Management Co.	25.00%	1,049		1,049	7
8	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	3,098		3,098	8
9	V	26 Insurance		kel-Tech Management Co.	25.00%	136		136	9
10	V	30 Depreciation		kel-Tech Management Co.	25.00%	150		150	10
11	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	182		182	11
12	V	34 Rent- Facility		kel-Tech Management Co.	25.00%	515		515	12
13	V	35 Rent - Equipment		kel-Tech Management Co.	25.00%	30		30	13
14	Total		\$			\$ 6,628	\$ *	6,628	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing	\$	kel-Tech Management Co.	25.00%	\$ 1,065	\$ 1,065
16	V	17 Administration		kel-Tech Management Co.	25.00%	5,037	5,037
17	V	21 Clerical		kel-Tech Management Co.	25.00%	7,503	7,503
18	V	6 Maintenance		kel-Tech Management Co.	25.00%	5,285	5,285
19	V						
20	V						
21	V	19 Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)
22	V	34 Building Lease	64,924	Krypton Land Trust	100.00%		(64,924)
23	V	32 Mortgage Interest		Krypton Land Trust	100.00%	30,751	30,751
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 88,924			\$ 49,641	\$ * (39,283)

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

Facility Name & ID Number

Krypton

0040212

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jacob L. Alley	50	Lincoln Square	Jonesboro				1
2	Diana Alley	50	Lincoln Square	Jonesboro				2
3	James A. Keller	50	Glen Brook of Vienna	Vienna				3
4	Norine Keller	50	Glen Brook of Vienna	Vienna				4
5	James K. Keller Family Trust	50	Pilot House	Cairo				5
6	JoAnn Keller	50	Pilot House	Cairo				6
7	JoAnn Keller	50	Mulberry Manor	Anna				7
8	James K. Keller Family Trust	50	Mulberry Manor	Anna				8
9	Don Pippins	50			CIL	Anna	CILA	9
10	Denise Pippins	50			CIL	Anna	CILA	10
11	Don Pippins	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	11
12	Jacob L. Alley	50			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	12
13	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	13
14	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	14
15	Don Pippins	25			Independent Living Se	Anna	CILA	15
16	Jacob L. Alley	25			Independent Living Se	Anna	CILA	16
17	James A. Keller	25			Independent Living Se	Anna	CILA	17
18	James K. Keller Family Trust	25			Independent Living Se	Anna	CILA	18
19	Don Pippins	25			ILS Land Trust	Anna	Land Trust	19
20	Jacob L. Alley	25			ILS Land Trust	Anna	Land Trust	20
21	James A. Keller	25			ILS Land Trust	Anna	Land Trust	21
22	James K. Keller Family Trust	25			ILS Land Trust	Anna	Land Trust	22
23	JoAnn Keller	25			JR Center	Anna	Workshop	23
24	Don Pippins	12.5			JR Center	Anna	Workshop	24
25	JoAnn Keller	25			ILS Land Trust	Anna	Land Trust	25
26	Jacob L. Alley, II	20			Krypton	Metropolis	CILA	26
27	Josh Alley	20			Krypton	Metropolis	CILA	27
28	Jacob L. Alley	30			Krypton	Metropolis	CILA	28
29	Diana Alley	30			Krypton	Metropolis	CILA	29
30								30

Facility Name & ID Number Krypton # 0040212 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		30.00	247				\$ 229	21-1	1
2	Diana Alley	Owner/QIDP	Program	30.00	21,056	2	5.00	QIDP	859	10-1	2
3	Josh Alley	Owner/RSD	Program	20.00		40	100.00	RSD	35,446	10-1	3
4	Ashley Alley	QIDP	Program	0.00	14,976	2	5.00	QIDP	1,024	10-1	4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	1,065	19-3	8
9	Jacob Alley							Maintenance	4,069	19-3	9
10	James A. Keller							Administration	5,037	19-3	10
11	Ashley Alley							Clerical	2,776	19-3	11
12											12
13								TOTAL	\$ 50,505		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: 01/01/2013

Ending: 2/31/2013

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	Houskeeping	Mgmt Fee Contribution	335,796	8	\$ 1,016	\$ 24,000	\$ 73	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	335,796	8	2,633	24,000	188	2
3	5	Utilities Water	Mgmt Fee Contribution	335,796	8	380	24,000	27	3
4	6	Maint. Building	Mgmt Fee Contribution	335,796	8	220	24,000	16	4
5	6	Maint. Supplies	Mgmt Fee Contribution	335,796	8	916	24,000	65	5
6	6	Grounds Maint.	Mgmt Fee Contribution	335,796	8	1,046	24,000	75	6
7	14	Maint. Vehicle	Mgmt Fee Contribution	335,796	8	1,133	24,000	81	7
8	14	Repairs Vehicle	Mgmt Fee Contribution	335,796	8	3,326	24,000	238	8
9	14	Transportation	Mgmt Fee Contribution	335,796	8	7,026	24,000	502	9
10	14	Insurance Vehicles	Mgmt Fee Contribution	335,796	8	1,028	24,000	73	10
11	19	Legal & Accounting	Mgmt Fee Contribution	335,796	8	1,115	24,000	80	11
12	20	Dues Fees Subscriptions	Mgmt Fee Contribution	335,796	8	699	24,000	50	12
13	21	G & A Supplies	Mgmt Fee Contribution	335,796	8	6,651	24,000	475	13
14	21	Postage	Mgmt Fee Contribution	335,796	8	2,122	24,000	152	14
15	21	Bank Charges	Mgmt Fee Contribution	335,796	8	131	24,000	9	15
16	21	IT Services	Mgmt Fee Contribution	335,796	8	1,580	24,000	113	16
17	21	Copier Expense Service Calls	Mgmt Fee Contribution	335,796	8	72	24,000	5	17
18	21	G&A Misc.	Mgmt Fee Contribution	335,796	8	195	24,000	14	18
19	21	Software Expense	Mgmt Fee Contribution	335,796	8	796	24,000	57	19
20	21	Telephone	Mgmt Fee Contribution	335,796	8	1,514	24,000	108	20
21	21	Cell Phone Expense	Mgmt Fee Contribution	335,796	8	1,246	24,000	89	21
22	21	Utilities - Internet	Mgmt Fee Contribution	335,796	8	369	24,000	26	22
23	22	Ins. Emp. Group	Mgmt Fee Contribution	335,796	8	19,832	24,000	1,417	23
24	22	Insurance W/C	Mgmt Fee Contribution	335,796	8	3,124	24,000	223	24
25	TOTALS					\$ 58,170	\$	\$ 4,156	25

Facility Name & ID Number Krypton

0040212 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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	22	Payroll Tax Expense	Mgmt Fee Contribution	335,796	8	\$ 20,383	\$ 24,000	\$ 1,457	1	
2	22	Misc. Emp Benefits	Mgmt Fee Contribution	335,796	8	(7)	24,000	(1)	2	
3	26	Insurance Bldg & Liab	Mgmt Fee Contribution	335,796	8	1,898	24,000	136	3	
4	30	Depreciation	Mgmt Fee Contribution	335,796	8	2,100	24,000	150	4	
5	33	Real Estate Taxes	Mgmt Fee Contribution	335,796	8	2,553	24,000	182	5	
6	34	Lease Bldg	Mgmt Fee Contribution	335,796	8	7,200	24,000	515	6	
7	35	Lease Equip	Mgmt Fee Contribution	335,796	8	425	24,000	30	7	
8	10	Nursing	Mgmt Fee Contribution	335,796	8	14,896	14,898	24,000	1,065	8
9	17	Administration	Mgmt Fee Contribution	335,796	8	70,444	70,454	24,000	5,035	9
10	21	Clerical	Mgmt Fee Contribution	335,796	8	104,923	104,937	24,000	7,499	10
11	6	Maintenance	Mgmt Fee Contribution	335,796	8	73,909	73,919	24,000	5,282	11
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 298,724	\$ 264,208	\$ 21,350	25	

Facility Name & ID Number

Krypton

0040212

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Old National Bank		X	2011 Handicap Van	\$573.08	10/2/13	\$ 25,608	\$ 24,062	10/2/17	3.5000	\$ 741	1						
2		Flemings		X	Facility Furniture	\$40.00	5/13/13	2,397	2,117	5/13/17			2						
3		Ashley's Furniture		X	Facility Furniture	\$62.00	6/5/13	1,472	1,100	6/5/18			3						
4													4						
5													5						
		Working Capital																	
6		Capaha Bank		X	Line of Credit		6/10/2013	150,000		6/10/2014	6.0000	1,729	6						
7		Mulberry Manor	X		Operating Capital		3/1/2008	100,000	75,000				7						
8		Krypton Land Trust	X		Operating Capital		5/1/2011		94,900		3.5000	2,174	8						
9		TOTAL Facility Related				\$675.08		\$ 279,477	\$ 197,179			\$ 4,644	9						
		B. Non-Facility Related*																	
10		Old National Bank		X	2008 Grand Caravan	\$264.72	9/23/13	11,829	11,133	9/23/17	3.5000	98	10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related				\$264.72		\$ 11,829	\$ 11,133			\$ 98	14						
15		TOTALS (line 9+line14)						\$ 291,306	\$ 208,312			\$ 4,742	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$	<u>5,702</u>	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>8,676</u>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,974</u>	3															
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>8,700</u>	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>11,674</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>5,104</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>5,204</u>	9																
	2010	<u>5,443</u>	10																
	2011	<u>5,703</u>	11																
	2012	<u>8,676</u>	12																
<u>Sch IX, Line 7</u>		<u>11,674</u>																	
<u>kel-Tech Allocation</u>		<u>182</u>																	
<u>CILA Property Taxes (5997)</u>																			
<u>Sch V, Line 33, Col. 8</u>		<u>5,859</u>																	

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Krypton COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0040212

CONTACT PERSON REGARDING THIS REPORT Ashley Alley

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 2012 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 2012.

(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>LT0018 BK060 LOTS 14 15 16 17 &</u>	\$ <u>5,679.62</u>	\$ <u>5,679.62</u>
2. <u>08-01-100-024</u>	<u>S01 T16 R04 50X126 FT PT SE NW</u>	\$ <u>129.26</u>	\$ _____
3. <u>08-01-100-023</u>	<u>S01 T16 R04 50X126 FT PT SE NW</u>	\$ <u>129.26</u>	\$ _____
4. <u>09-02-100-022</u>	<u>S02 T16 R05 PT NW</u>	\$ <u>1,598.04</u>	\$ _____
5. <u>06-19-400-024</u>	<u>S19 T15S R5E PT CENT S 1/2 SW S1</u>	\$ <u>1,140.14</u>	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>8,676.32</u></u>	\$ <u><u>5,679.62</u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

0040212 Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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:

	1	2	3	4	
A. Land.	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	TOTALS	<u>37,500</u>		<u>\$ 8,000</u>	<u>3</u>

Facility Name & ID Number Krypton

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1984	1984	\$ 136,550	\$		\$ 4,213	\$ 4,213	\$ 132,681
5									
6									
7									
8									
Improvement Type**									
9	Carpet		2003	1,050		5			1,050
10	8x12 Economy Barn		2004	1,057		10	103	103	1,057
11	Water Heater & Vent		2004	2,109		7			2,109
12	Water Heater		2005	1,733		7			1,733
13	Roof		2005	6,300	420	15	420		3,570
14	Living Room Carpet		2006	922		7	64	64	922
15	Remodeling		2007	25,739	1,519	15	1,716	197	10,743
16	Flooring		2007	29,494	2,634	7	4,215	1,581	27,390
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Krypton

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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				
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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)	\$	204,954	\$	4,573	\$	10,731	\$	6,158	\$	181,255	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 21,414	\$ 1,072	\$ 3,141	\$ 2,069		\$ 13,442	71
72	Current Year Purchases	6,196	1,214	606	(608)		606	72
73	Fully Depreciated Assets	24,724					24,724	73
74	Non-Care Assets	9,393	1,866		(1,866)		1,866	74
75	TOTALS	\$ 61,727	\$ 4,152	\$ 3,747	\$ (405)		\$ 40,638	75

D. Vehicle Costs. (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	\$ 24,934	\$	\$	\$	5	\$ 24,934	76
77	Healthcare	2001 Chev. Pickup	2002	14,000				5	14,000	77
78	Healthcare	2008 Ford Focus	2008	15,503	447	1,549	1,102	5	15,503	78
79	See Pg. 24			52,261	9,890	4,707	(5,183)		10,612	79
80	TOTALS			\$ 106,698	\$ 10,337	\$ 6,256	\$ (4,081)		\$ 65,049	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)	\$ 381,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,062	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,734	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,672	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 286,942	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	2013 Furniture/Fixtures New CILAs	\$ 9,393	\$ 1,866	\$ 1,866	86
87	2013 - '08 Dodge Caravan for CILA	11,829	2,366	2,366	87
88					88
89					89
90					90
91	TOTALS	\$ 21,222	\$ 4,232	\$ 4,232	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: 01/01/2013

Ending: 12/31/2013

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. _____/2014 \$ _____

13. _____/2015 \$ _____

14. _____/2016 \$ _____

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: \$ 1,037 Description: Copier Lease

(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.

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>
--	---	--

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)	264	3,076		3,340
4	Clinical Wages (b)	515	5,998		6,513
5	In-House Trainer Wages (c)	947	11,037		11,984
6	Transportation				
7	Contractual Payments	490	1,470		1,960
8	CNA Competency Tests				
9	TOTALS	\$ 2,216	\$ 21,581	\$	\$ 23,797
10	SUM OF line 9, col. 1 and 2 (e)	\$ 23,797			

- (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.

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	8

- (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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		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 prescrpts													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	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: 01/01/2013Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	\$ 15,115	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,311		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)	66,497		8
9	Other(specify): <u>DSP Trn'g Reimbursable</u>	11,298		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 107,221	\$	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	68,407		15
16	Equipment, at Historical Cost	165,518		16
17	Accumulated Depreciation (book methods)	(163,609)		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)	\$ 70,316	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 177,537	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,360	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,859		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,797		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Credit Card Payable</u>	1,657		36
37	<u>Payroll Liabilites Payable</u>	515		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 45,888	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	207,074		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Auto Loans Payable</u>	35,195		43
44	<u>Short Term Loans Payable</u>	3,216		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 245,485	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 291,374	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (113,836)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 177,538	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (37,206)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (37,206)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(76,630)	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)	\$ (76,630)	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)	\$ (113,836)	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 611,524	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 611,524	3	
B. Ancillary Revenue				
4	Day Care	141,682	4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 141,682	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements	13,296	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)	\$ 13,296	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	131	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 131	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 766,633	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	96,243	31	
32	Health Care	507,514	32	
33	General Administration	100,489	33	
B. Capital Expense				
34	Ownership	107,867	34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee	31,150	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 843,263	40	
41	Income before Income Taxes (line 30 minus line 40)**	(76,630)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (76,630)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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: 01/01/2013

Ending: 12/31/2013

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	735	25,815	35.12	3
4	Licensed Practical Nurses	38	564	14.84	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	2,484	31,916	11.81	11
12	Dietician				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				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,411	16,115	11.41	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	775	21,456	27.69	28
29	Resident Services Coordinator	516	14,304	27.72	29
30	Habilitation Aides (DD Homes)	24,038	236,175	9.53	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	29,997	346,345 *	11.19	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	16	\$ 654	1-3	35
36	Medical Director	50	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	1,075	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist Cons.</u>	21	1,600	10a-3	46
47	<u>Social Work Cons.</u>	63	3,490	12-3	47
48					48
49	TOTAL (lines 35 - 48)	179	\$ 10,659		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
				Workers' Compensation Insurance	\$ 8,963	IDPH License Fee	\$		
				Unemployment Compensation Insurance	2,433	Advertising: Employee Recruitment		111	
				FICA Taxes	26,224	Health Care Worker Background Check			
				Employee Health Insurance	2,188	(Indicate # of checks performed)		48	
				Employee Meals	1,615	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Pg. 24		1,532	
				Misc. Employee Benefits	484	kel-Tech Allocation		50	
				kel-Tech Allocation	3,098				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount	Less: CILA Staff Expenses	(4,138)	Less: Public Relations Expense	(
			\$	Less: Staff Meals	(1,615)	Non-allowable advertising	(
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 39,252	TOTAL (agree to Sch. V, line 20, col. 8)	\$	1,741	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount		
Barnett & Levine	CPA	\$ 1,475			\$	Out-of-State Travel	\$		
FMGR	Legal	1,291							
kel-Tech Management Co.	Management Services	24,000				In-State Travel			
						Hotel Room		127	
						Seminar Expense			
						Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,766	TOTAL	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$	127	

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Krypton# 0040212Report Period Beginning: 01/01/2013 Ending: 12/31/2013**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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 941 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 3/1/2008
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,150
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? Yes 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. \$ 1,615 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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?
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: _____
- (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.

Krypton
Analysis of Sch XIX, Section F.
2013

Resident Acct Bond Renewal	\$	180
P.O. Box Rental		70
IL Corp Ann Report		124
Sams Club Membership		45
Subscriptions/Fees		301
CILA Fees		403
License Plate Fees		412
Fingerprinting		400
Less:		
CILA Fees		(403)
Total	\$	<u>1,532</u>

Krypton
Analysis Allocated Hours & Wages
Sch18, Line 29 & 30, Col 1-4
2013

Josh Alley, RSD/QMRP

QIDP	60%	21,268
RSD	40%	14,178
Total	100%	\$35,446

Krypton
Analysis of Depreciation
2013

Sch XI, Line 83	\$ 20,734
CILA Depreciation Expense	\$ 4,232
kel-Tech Mgmt Allocation	<u>150</u>
Sch. V, Line 30, Col. 8	<u>\$ 25,116</u>

Krypton, Inc.
Allocation of Real Estate to Nursing Home
Schedule IX
2013

Krypton ICF-DD	5,680
Krypton CILA	2,738
Krypton Future CILA Site	259
Total R/E Tax Expense	8,677

Krypton, Inc.
 Details for Sch. XI, Line 79
 2013

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare	2003 Jeep Wrangler	2010	6637	765	1327	562	5	4866
Healthcare	2011 E350 Van	2013	33795	6759	3380	-3379	5	3380
Non-Care Assets	2008 Dodge Caravan	2008	11829	2366	0	-2366	5	2366
			52261	9890	4707	-5183		10612