THE COMMONWEALTH OF MASSACHUSETTS CENTER FOR HEALTH INFORMATION AND ANALYSIS

501 BOYLSTON STREET BOSTON, MASSACHUSETTS 02116

2020 HCF-3

MANAGEMENT and/or CENTRAL OFFICE REPORT

Batch #

1. Management/Central Office Identification Number COMB-

2. Balance Sheet Date of Management Company

and/or Central Office (MO-DA-YR)

3. Name of Management Company

and/or Central Office

Street Address

City

State Zip

4. Telephone ( ) Area Code - Number

5. FAX ( ) Area Code - Number

Contact Information:

Name:

Phone:

Address:

Email Address:

The HCF-3 should be completed when expenses are included on the HCF-4 in the "Management Fees" account 4160.3 or when any Central Office expense is paid or claimed. It must be returned to this office accompanied by the HCF-4. The HCF-3 serves the dual purpose of being a report to the Center by providers to accurately reflect the complete financial condition of the entity and is, at the same time, a claim for reimbursement.

Please type or print using BOLD, BLACK INK. Use whole dollar amounts and accounts with no dollar amounts should be left blank. Use N/A on all schedules that are not applicable.

THIS REPORT IS DUE:

June 4, 2021 WHEN FILED WITH THE HCF-1 and HCF-4.

For assistance in completing this form, email the Help Desk @ [CHIAcostreports.LTFC@state.ma.us.](mailto:CHIAcostreports.LTFC@state.ma.us)

\* Entities filing multiple HCF-3 reports should add an appropriate letter (A, B, C...) at the end of the identification number.

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

CERTIFICATION BY OWNER, PARTNER OR OFFICER

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost

Report and supporting schedules prepared for:

Provider Name Combine Number

for the Cost Report period beginning

and ending

and that to the best of my knowledge and belief, the statement, accompanying Cost Report, and supporting schedules are true, accurate and complete and prepared in accordance with applicable regulations and instructions, and that the statement, Cost Report, and supporting schedules are prepared from the books and records of the provider(s) except as noted. If prepared by a person other than owner, partner, or officer, this declaration is based on all information of which the preparer has knowledge.

This certification is signed under pains and penalties of perjury. Facsimile signatures are not acceptable.

Name of Owner, Partner, or Officer

Last Name

First Name M.I.

Email Address

Title Date of Signature (MO-DA-YR)

Signature of Owner, Partner or Officer

(See Schedule A - Disclosure Information - and the instructions thereon.)

Name of Preparer other than Owner, Partner or Officer

Firm/Company Name

Preparer’s Name

Preparer’s Title

Preparer’s Address

Phone

Email Address

Date of Signature (MO-DA-YR)

Signature of Preparer other than Owner, Partner or Officer

Type of Accounting Service Performed 1

1 A = Audit R = Review C = Compilation O = Other

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SCHEDULE A - DISCLOSURE INFORMATION

Answer all questions. Use N/A if applicable. Facsimile signatures are not acceptable. If extra space is needed, please photocopy form.

Instructions:

a) Schedule A is an integral part of the HCF-3 form. This schedule must be completed in its entirety and signed by each owner with an interest of 5% or more. Signatures of Board of Directors members are required from publicly held corporations. An individual signing for an estate must indicate his legal capacity to sign for the estate.

b) A direct owner is a person or entity having any rights or benefits of ownership and having an interest of record in any partnership, joint venture, corporation or other entity.

c) An indirect beneficial owner is a person having any benefits or rights of ownership, either direct or indirect, through one or more intermediaries, through any understanding or relationship with a person or entity, resulting in benefits of ownership which are not of record. It is incumbent upon the owner to fully disclose such interest. FAILURE TO DISCLOSE THIS INFORMATION WILL BE SUBJECT TO

SANCTIONS AS PRESCRIBED UNDER REGULATION 101 CMR 204.00.

1. List all direct and indirect owners with an interest of 5% or more in this company. If the company is owned by a corporation or chain, list the name of the corporation under “Last Name”. If the company is held under a trust, the beneficial owner(s) must be identified under “Last Name”.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name | First Name | MI | Address | Percent  Ownership | Direct or  Indirect |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

2. List the name(s) of any other nursing facilities or rest homes in which the owners listed in item #1 own, directly or indirectly, an interest of 5% or more.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rest Home | VPN | Name of Owner | Address of Company | % Ownership |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

3. List any indebtedness (mortgages, deeds, trust instruments, notes or other financial information) of the company to the direct or indirect owners listed in item #1.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Creditor | Original debt amount | Date Issued | Balance 12/31/2020 | Name of Owner |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

4. List any indebtedness (mortgages, deeds, trust instruments, notes or other financial information) of the direct or indirect owner listed in item #1 to the company.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Creditor | Original debt amount | Date Issued | Balance 12/31/2020 | Name of Owner |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

5. Indicate any entity, person or related party as defined in REGULATION 101 CMR 204.00 and that (a) provides services, facilities, goods and/or supplies to this company; or (b) receives any salary, fee or other compensation from this company. Indicate the amount paid by this company for this reporting year. (Attach addendum if necessary.)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Entity/Person | Goods/Services | Billing/ Compensation | Mark up | Cost | Account  Posted | Name of Owner | % Ownership |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

CERTIFICATION

The undersigned certifies, under penalty of perjury, that he has read the Disclosure Information, has completed Schedule A, and that the schedule is a true and correct statement of all such interest in this company.

SIGNATURE:

TITLE:

DATE:

SIGNATURE:

TITLE:

DATE:

SIGNATURE:

TITLE:

DATE:

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PROPRIETORSHIP, PARTNERSHIP OR CORPORATE INFORMATION

FAILURE TO INCLUDE DOLLAR AMOUNTS AND ACCOUNT NUMBERS, EVEN IF NOT CLAIMING FOR REIMBURSEMENT, MAY RESULT IN A DELAY OF YOUR RATE.

Sole Proprietorship:

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | #2530.01 | # XXX | # XXX | # XXX | # XXX |
| % Time Devoted | % | XXX % | XXX % | XXX % | XXX % |
| Salary | $ XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Employee Benefits | $ XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Payroll Taxes | $ XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Workers’ Comp. | $ XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Gr. Life/Health Ins. | $XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Draw: | $ | $ XXX | $ XXX | $ XXX | $ XXX |
| Other: | $ XXX | $ XXX | $ XXX | $ XXX | $ XXX |
| Total | $ | $ XXX | $ XXX | $ XXX | $ XXX |

First Name

Title

Partnership:

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | #2540.01 | # | # | # | # |
| % Time Devoted | % | % | % | % | % |
| Salary | $ XXX | $ | $ | $ | $ |
| Employee Benefits | $ XXX | $ | $ | $ | $ |
| Payroll Taxes | $ XXX | $ | $ | $ | $ |
| Workers’ Comp. | $ XXX | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ XXX | $ | $ | $ | $ |
| Draw: | $ | $ | $ | $ | $ |
| Other: | $ XXX | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

Circle one:

Owner / Officer / Partner

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | #2540.01 | # | # | # | # |
| % Time Devoted | % | % | % | % | % |
| Salary | $ XXX | $ | $ | $ | $ |
| Employee Benefits | $ XXX | $ | $ | $ | $ |
| Payroll Taxes | $ XXX | $ | $ | $ | $ |
| Workers’ Comp. | $ XXX | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ XXX | $ | $ | $ | $ |
| Draw: | $ | $ | $ | $ | $ |
| Other: | $ XXX | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

Circle one:

Owner / Officer / Partner

Corporation:

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | # | # | # | # | # |
| % Time Devoted | % | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

Owner / Officer / Partner

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | # | # | # | # | # |
| % Time Devoted | % | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

Owner / Officer / Partner

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Account | # | # | # | # | # |
| % Time Devoted | % | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

Owner / Officer / Partner

1Annual Draw or Earnings Distribution

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SCHEDULE OF HIGHEST PAID SALARIES

List below the names, salaries and benefits of the three employees who have the highest compensation being claimed on this report. In columns (a) through (d) identify the account where the employee expense is claimed, as well as the additional information.

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | (a+b+c+d) | (a) | (b) | (c) | (d) |
| Account | Total | # | # | # | # |
| % Time Devoted | 100% | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Draw | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

(7710.1)

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | (a+b+c+d) | (a) | (b) | (c) | (d) |
| Account | Total | # | # | # | # |
| % Time Devoted | 100% | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Draw | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

(7711.1)

Last Name

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | (a+b+c+d) | (a) | (b) | (c) | (d) |
| Account | Total | # | # | # | # |
| % Time Devoted | 100% | % | % | % | % |
| Salary | $ | $ | $ | $ | $ |
| Employee Benefits | $ | $ | $ | $ | $ |
| Payroll Taxes | $ | $ | $ | $ | $ |
| Workers’ Comp. | $ | $ | $ | $ | $ |
| Gr. Life/Health Ins. | $ | $ | $ | $ | $ |
| Draw | $ | $ | $ | $ | $ |
| Other: | $ | $ | $ | $ | $ |
| Total | $ | $ | $ | $ | $ |

First Name

Title

(7712.1)

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FOOTNOTES AND EXPLANATIONS

Enter any footnotes, explanations or disagreements relating to this cost report in the space provided below. The Center relies on accurate reporting which is consistent with regulations, forms, instructions and advisory rulings. Providers should report both actual and allowable costs and explain all discrepancies. Please attach an additional page if needed.

---------------------------------------------------------------------------------------------------------------------------------------- Have you reported any costs on a related HCF-4 directly, which were not allocated through Schedule 10? Circle Yes or No: Yes No

If Yes, explain in detail in the footnotes and explanations giving the account(s) and the dollar amount(s)

of the entry.

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SCHEDULE 1: BALANCE SHEET (DOLLARS ONLY - DO NOT RECORD CENTS) ASSETS

Current Assets

Cash

Checking Account (1020.0)

On Hand (1030.0)

Temporary Investments (1040.0)

Other (1050.0)

Total Cash (1010.0)

Accounts Receivable (1070.0)

Loans Receivable

|  |  |  |
| --- | --- | --- |
| Due from Officers/Owner | (1160.0) |  |
| Due from Employees | (1170.0) |
| Subsidiaries and/or Affiliates | (1180.0) |
| Other Loans Receivable | (1185.0) |
| Total Loans Receivable | (1150.0) |
| Supply Inventory | (1210.0) |
| Prepaid Expenses  Prepaid Interest | (1270.0) |
| Prepaid Insurance | (1280.0) |
| Capitalized Pre-Opening Costs | (1295.0) |
| Other Prepaid Expenses\* | (1300.0) |
| Total Prepaid Expenses | (1260.0) |
| Other Current Assets | (1310.0) |
| Total Current Assets |  | (1005.0) |
| Fixed Assets |  |  |
| Cost | (1511.1) |  |

Land

Book Value (1510.0)

Building

Cost (1521.1)

Accum. Depr. (1522.2) ( )

Book Value (1520.0) Building Improvements

Cost (1611.1)

Accum. Depr. (1612.2) ( )

Book Value (1610.0) HCF Capitalization-Improvements

Cost (1616.1)

Accum. Depr. (1617.2) ( )

Book Value (1615.0) Equipment

Cost (1651.1)

Accum. Depr. (1652.2) ( )

Book Value (1650.0)

\* See Instructions

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HCF Capitalization- Equipment

|  |  |
| --- | --- |
| Cost | (1661.1) |
| Accum. Depr. | (1662.2) ( ) |
| Book Value | (1660.0) |
| Motor Vehicles  Cost | (1701.1) |
| Accum. Depr. | (1702.2) ( ) |
| Book Value | (1700.0) |
| Software/Limited Life Assets  Cost | (1710.1) |
| Accum. Depr. | (1710.2) ( ) |
| Book Value | (1710.0) |
| HCF Capitalization-Software/Li  Cost | mited Life Assets  (1715.1) |
| Accum. Depr. | (1715.2) ( ) |
| Book Value | (1715.0) |

Total Fixed Assets (1500.0)

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Deferred Charges and Other Assets

Purchased Goodwill (1940.0)

Utility Deposits (1960.0)

Investments (1965.0)

Cash Surrender Value of

Officer Life Insurance (1970.0)

Mortgage Acquisition Cost\* (1975.1)

Accumulated Amortization of

Mortgage Acquisition Cost (1975.2) ( )

Unamortized Mortgage Acquisition

Cost (1975.0)

Other1 (1980.0)

Total Deferred Charges and Other Assets (1900.0)

TOTAL ASSETS (1000.0)

LIABILITIES AND NET WORTH

Current Liabilities

Accounts Payable

Trade (2020.0)

Accrued Expenses (2030.0)

Total Accounts Payable (2010.0)

Notes and Loans Payable (See Schedule 5) Officer, Owner or

Related Parties (2110.0)

|  |  |
| --- | --- |
| Subsidiaries & Affiliates | (2120.0) |
| Banks | (2130.0) |
| Other Short-Term Financing | (2150.0) |
| Payments Due w/in One Yr on  Long-Term Debt\* | (2160.0) |
| Total Notes and Loans Payable | (2100.0) |

Accrued Salaries & Payroll Liabilities

Accrued Salaries (2190.0)

Accr. Payroll Tax W/held (2200.0)

Accr. Employee Taxes Pay. (2210.0)

Other Payroll Liabilities (2220.0)

Total Accrued Salaries & Payroll Liabilities (2180.0)

Accrued Taxes-Realty & Management (2240.0)

Other Current Liabilities (2295.0)

Total Current Liabilities (2005.0)

\* See Instructions

1 Explain "Other" in the Footnotes and Explanations section of this report.

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Long-Term Liabilities (See Schedule 5)

Mortgages\* (2310.0)

Other Long Term Debt\* (2320.0)

Total Long-Term Liabilities (2300.0)

Net Worth

Proprietorship or Partnership

|  |  |  |
| --- | --- | --- |
| Capital | (2520.0) |  |
| Proprietor Drawings | (2530.0) ( ) |  |
| Partnership Drawings | (2540.0) ( ) |  |
| Contributions | (2545.0) |  |
| Net Profit (loss) Year to Date | (2550.0) |  |
| Total Proprietorship or Partnership | (2510.0) |  |
| Corporation  Capital Stock | (2620.0) |  |
| Additional Paid in Capital | (2630.0) |  |
| Treasury Stock | (2640.0) ( ) |  |
| Retained Earnings | (2650.0) |  |
| Total Corporation | (2610.0) |  |
| Total Net Worth |  | (2500.0) |

TOTAL LIABILITIES AND NET WORTH (2000.0)

\* See Instructions

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SCHEDULE 2: STATEMENT OF PROFIT AND LOSS (For Year Ending December 31, 2020) INCOME

Residential Care Facilities (3630.0)

Other (Attach Explanation) (3650.0)

A & G Recoverable Income (3650.4)

Variable Recoverable Income (3650.5)

Director of Nurses Recoverable Income (3650.2)

Fixed Recoverable Income (3650.3)

TOTAL INCOME (3600.0)

OPERATING EXPENSES

Administration Salaries

|  |  |  |  |
| --- | --- | --- | --- |
| Administration Salaries3 | A & G | (9312.1) |  |
| Administrator-in-Training | A & G | (9313.1) |  |
| Administrator | A & G | (9314.1) |  |
| Total Administration Salaries |  |  | (9310.0) |

Officer/Owner Compensation

|  |  |  |  |
| --- | --- | --- | --- |
| Officer/Owner | N | (9316.1) |  |
| Directors' Fees | N | (9317.3) |
| Total Officer/Owner Compensation |  |  | (9315.0) |
| Other Administrative, Variable & DON Costs  Other Management Fees (submit supplemental HCF-3) | N | (9321.0) |  |
| Clerical1 | A & G | (9321.1) |  |
| Payroll Service/EDP | A & G | (9322.3) |  |
| Other2 | A & G | (9323.7) |  |
| Quality Assurance Professional | V | (9323.1) |  |
| Indirect Restorative Therapy | V | (9323.5) |  |
| Direct Restorative Therapy | N | (9323.6) |  |
| Dietitian | V | (9323.4) |  |

Total Other Administrative &Variable Costs (9320.0)

Office Supplies A & G (9325.0)

Telephone

Phone(s) A & G (9331.5)

Advertising N (9332.6)

Total Telephone (9330.0)

Travel and Motor Vehicle Service

Motor Vehicle Expense N (9336.5)

1 Provide details of Clerical Expense (9321.1) on Schedule 16.

2 Provide details of Other Administrative Costs (9323.7) on Schedule 19.

3 Provide details of Administration Salaries Expense (9312.1) on Schedule 17.

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|  |  |  |  |
| --- | --- | --- | --- |
| Conventions & Meetings | A & G | (9338.6) |  |
| Other (explain) | A & G | (9339.6) |  |
| Total Travel & Motor Vehicle Services |  |  | (9335.0) |

Advertising

Help Wanted Advertising A & G (9341.5)

Other N (9342.6)

Total Advertising (9340.0)

Licenses and Dues A & G (9345.0)

Group Life/Health Insurance & Pension

|  |  |  |
| --- | --- | --- |
| Administration | A & G | (9351.6) |
| Officer/Owner/Directors | N | (9351.7) |
| Other A & G Employees | A & G | (9351.4) |
| Variable Employees | V | (9351.5) |

Total Group Life/Health Ins. & Pension (9350.0)

Accounting

|  |  |  |  |
| --- | --- | --- | --- |
| Appeal Services | N | (9361.3) |  |
| Other | A & G | (9362.7) |  |
| Total Accounting |  |  | (9360.0) |

Legal

Appeal Service N (9366.3)

Other N (9367.7)

Total Legal (9365.0)

Payroll Taxes

Administration A & G (9371.2)

|  |  |  |
| --- | --- | --- |
| Officer/Owner/Directors | N | (9371.3) |
| Other A & G Employees | A & G | (9371.4) |
| Variable Employees | V | (9371.5) |

Total Payroll Taxes (9370.0)

Insurance

General1 A & G (9377.3)

Workers’ Compensation

Administration A & G (9376.2)

Officer/Owner/Directors N (9373.1)

Other A & G Employees A & G (9373.4)

Variable Employees V (9373.5)

Total Insurance (9375.0)

Miscellaneous 2 A & G (9379.0)

1. Provide details of General Insurance (9377.3) on Schedule 20.

2. Provide details of Miscellaneous Expenses (9379.0) on Schedule 21.

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|  |  |  |
| --- | --- | --- |
| Real Estate Taxes | F | (9380.0) |
| Personal Property Taxes | F | (9380.1) |
| Insurance-Building, Building Improvements, Equipment | F | (9380.5) |
| Interest, Long-Term (see Schedule 5) | F | (9381.0) |
| Interest on Late Payments, Penalties | N | (9381.5) |
| Interest on Working Capital (See Sch. 5) | N | (9381.7) |

|  |  |
| --- | --- |
| Item | Expense |
| Equipment Rental |  |
| Other (Explain) |  |
| Other (Explain) |  |
| Total Other (9382.0) |  |

Rent (HCF-2 is required for related parties) F (9382.0)

Depreciation

Building F (9386.8)

|  |  |  |  |
| --- | --- | --- | --- |
| Improvements | F | (9387.8) |  |
| HCF Capitalization-Improvement | F | (9387.9) |
| Equipment | F | (9388.8) |
| HCF Capitalization-Equipment | F | (9388.9) |
| Software/Limited Life Assets | F | (9390.8) |
| HCF Capitalization-Software/Limited Life Assets | F | (9390.9) |
| Total Depreciation |  |  | (9385.0) |
| Maintenance |  | A & G | (9390.0) |
| Other Property Costs1 |  | A & G | (9391.0) |

------------------------------------------------------------------------------------------------------------------------------------------------------------------ Total Expenses are summarized on the next page.

1 Provide details of Other Property Expenses (9391.0) on Schedule 22.

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The accounts below summarize reported expenses and non-allowable costs by cost center. All HCF-3 costs must be reported in this manner to facilitate the transfer of costs from the HCF-3 to the HCF-4.

REPORTED EXPENSES BY TYPE

Total Fixed Costs\* F (9300.1)

Total A & G Expenses\* A & G (9300.5)

Total Variable Expenses\* V (9300.6)

Total Automatic Disallowed Expenses\* N (9300.4)

TOTAL REPORTED EXPENSES (9300.0)

NON-ALLOWABLE EXPENSES BY TYPE

Total Self Disallowed Fixed Costs (Sch. 14) F (9301.1)

Total Self Disallowed A & G (Sch. 14) A & G (9301.5)

Total Self Disallowed Variable (Sch. 14) V (9301.6)

Total Automatic Disallowed Expenses (Sch. 13) N (9301.4)

TOTAL NON-ALLOWABLE EXPENSES (9301.0) ( )

------------------------------------------------------------------------------------------------------------------------------------------------------------------ ADJUSTED EXPENSES BY TYPE

Total HCF-3 Fixed Costs (from Schedule 15) F (9302.1)

Total HCF-2 Fixed Costs (from Schedule 15) F (9302.9)

Total A & G Expenses (9300.5 less 9301.5) A & G (9302.5)

Total Variable Expenses (9300.6 less 9301.6) V (9302.6)

Total Automatic Disallowed Expenses N (9302.4)

HCF-2 Other Operating Expense Add-Back A & G (9502.2)

TOTAL ADJUSTED EXPENSES (9302.0)

------------------------------------------------------------------------------------------------------------------------------------------------------------------ TOTAL ADJUSTED EXPENSES (9302.0) MUST EQUAL (9302.0) ON SCHEDULE 10.

\* See Instructions

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Management Company/Central Office Name

Balance Sheet Date (MO-DA-YR)

2020 HCF-3

SCHEDULE 5: ANALYSIS OF MORTGAGES AND NOTES PAYABLE

1. Mortgages and Notes Supporting Fixed Assets 1

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Lender  Name | Rel. Party Y/N | Date Mort. Acquired Mo-Da-Yr | Due Date  Mo-Da-Yr | No. of Months Amort. | Monthly  Payments | Original Mortgage Amount | Mort. Acq. Costs | Amort. of Mort. Acq Costs | Bal.  1/1/2020 | Principal  Payment | Bal.  12/31/2020 | Rate  % | Interest  Expense | Period  Expense |
| 1st Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2nd Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chattel Note |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chattel Note |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Capital Lease |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals | XXXXX | XXX | XXXXX | XXXXX | XXXX | XXXXX | XXXXX |  | a | XXXX | XXXXX |  | XXX | b | c |

2. Working Capital Debt

Total Fixed Interest a + b + c (9381.0)1 $

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | Lender Name | Rel. Party  Y/N | Balance  1/1/2020 | Amount | Start  Mo-Da-Yr | Principal  Payment | Balance  12/31/2020 | Interest Rate  % | Interest Expense2 |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |

Total Working Capital Interest (9381.7)2 = $

Total Working Capital Debt (2100.0 less 2160.0) = $

1This schedule should include all mortgages and notes payable whether or not interest expense is incurred. Each new note should be reported with all information items filled in completely. New notes or enhancements of existing notes should be reported on new line separately.

2The sum of the working capital interest expense.

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SCHEDULE 7: RECONCILIATION OF INCOME PER REPORT WITH INCOME PER BOOKS

Total Income Per Report (Account #3600.0) $

Total Operating Expenses (Account #9300.0) $

HCF-3 Net Income (Loss) before reconciling items $ 1

Reconciling Items:

Items recorded on this Report but not on Books. Explain Below.

|  |  |
| --- | --- |
|  | $ |
|  | $ |
|  | $ |
|  | $ |

Items recorded on Books but not on this Report. Explain Below.

$

$

$

$

Net Reconciling Items $

NET INCOME (LOSS) PER BOOKS $ 2

Comments/Explanations of Reconciling Items:

1 This amount should agree with Schedule 8, line 4 for Proprietorship and Partnership or line 5 for Corporations.

2 Do not use this amount on Schedule 8.

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SCHEDULE 8: RECONCILIATION OF NET WORTH

PROPRIETORSHIP AND PARTNERSHIP

1. Balance 12/31/2019 (2500.0) 1

2. Other: Prior Period Adjustment(s) 2

3. Capital Contribution during year

4. HCF-3 Net Income (Loss) Sch. 7

5. Drawing during year ( )

6. Balance 12/31/2020 (2500.0)

3

CORPORATION

DO NOT CHANGE ANY HEADING NAMES BELOW

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Capital | Additional | Retained | Treasury |  |
| Stock | Paid-In | Earnings | Stock | Total |
| (2620.0) | (2630.0) | (2650.0) | (2640.0) | (2500.0) |

1. Balance 12/31/2019 1 1

2. Other:

Prior Period

Adjustments:2 xxxxxxxxxxxx

xxxxxxxxxxxx 2

3. Sale of Stock

xxxxxxxxxxxx xxxxxxxxxxxxx xxxxxxxxxxxx

4. Additional Paid-

In Capital xxxxxxxxxxxx

xxxxxxxxxxxxx xxxxxxxxxxxx

5. HCF-3 Net Income

(Loss) Sch. 7 xxxxxxxxxxxx xxxxxxxxxxxxx

xxxxxxxxxxxx

6. Dividends Paid xxxxxxxxxxxx xxxxxxxxxxxxx ( ) xxxxxxxxxxxx ( )

7. Treasury Stock

Purchased/Sold xxxxxxxxxxxx xxxxxxxxxxxxx

8. Balance 12/31/2020 3

3

(2620.0) (2630.0) (2650.0) (2640.0) (2500.0)

1. This amount should agree with acct. #2500.0 , Total Net Worth, page 9, on 2019 HCF-3.

2. Disclose all facts relative to adjustment(s) and explain any impact on reimbursable cost as reported on prior year(s) cost report identifying the specific accounts affected.

3. This amount should agree with acct. #2500.0, Total Net Worth, page 10, on 2020 HCF-3. Detail explanation for any difference.

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Management Company/Central Office Name

Balance Sheet Date (MO-DA-YR)

2020 HCF-3

SCHEDULE 10: MANAGEMENT COMPANY/CENTRAL OFFICE EXPENSE ALLOCATION

Part 1: Provide allocation to Massachusetts Nursing and Rest Homes, Non-Mass Nursing and Rest Homes and Other Non-Nursing Home business in the grid below.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | # Beds | (A)  Shared A & G Expense | | (B) Other Direct  A & G Facility  Services2 | (C) = A + B Total HCF-3  A & G Add-back | (D)  Direct A & G (Admin.-in- Training &  Administrators1)  (from Part 4) | (E)  HCF-2-NH Other  Operating  Add-back3 | | (F)  Direct Variable (Dietician, Indirect Therapy  & QA1)  (from Part 3) | (G) Direct  Dir. of Nurses1  (from Part 2) | (H)  Total Fixed Expense  (from Schedule 15) | | (I) = C + D + E + F + G + H  Total Claimed  Expenses |
| Part 1a: Massachusetts Nursing and Rest Homes Only |  |  | % | $ | $ | $ | $ | % | $ | $ | $ | % | $ | $ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1a: TOTAL MASS NH & RH | XXXX | XXX |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | (A1) | | (B1) | (C1) | (D1) | (E1) | | (F1) | (G1) | (H1) | | (I1) |
| Part 1b: TOTAL NON-MASS NH & RH | XXXX | XXX |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | (A2) | | (B2) | (C2) | (D2) | (E2) | | (F2) | (G2) | (H2) | | (I2) |
| Part 1c: TOTAL NON-NH BUSINESS | XXXX | XXX |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | (A3) | | (B3) | (C3) |  | (E3) | |  |  | (H3) | | (I3) |
| TOTAL ADJUSTED MANAGEMENT CO. /CENTRAL OFFICE EXPENSES | XXXX | XXX |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | (A4) = A1+A2+A3 | | (B4) =  B1+B2+B3 | (C4) =  C1+C2+C3 | (D3) =  D1 + D2 | (E4) =  E1+E2+E3 (9502.2) = E4  Report on Sch. 2 | | (F3) =  F1 + F2 | (G3) =  G1 + G2 | (H4) =  H1+H2+H3 (9302.1+ 9302.9)= H4  Report on Sch. 2 | | (I4) = I1+I2+I3  (9302.0) = I4  Report on  Sch. 2 |
| (9302.5) = C4 + D3  Report on Sch. 2 | | (9302.6) = F3  Report on  Sch. 2 | (9302.8) = G3  Report on  Sch. 2 |

Explain Allocation Method(s) Used Above

1 Use Part 2 for Director of Nursing, Part 3 for Dietician, Physical/Occupational Therapy, Quality Assurance Professional and Part 4 for Administrator and Administrator-in-Training..

2 State reasons for Direct Expense Allocation (Attach Schedules as Necessary)

3 HCF-2 Other Operating Add-back must equal the claimed amount reflected in the HCF-2-NH, Schedule 3 or HCF-2-RH, Schedule 4 (account#9502.2).

NOTE: Total A & G expenses (Column C) and HCF-2 Other Operating (Column E) for each facility must equal the total HCF-3 A & G add-back on the HCF-1/HCF-4. Total Fixed Expenses must equal the Fixed Cost add-back claimed on HCF-1/HCF-4.

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Management Company/Central Office Name

Balance Sheet Date (MO-DA-YR)

2020 HCF-3

SCHEDULE 10: DIRECT ALLOCATION ONLY (Massachusetts Nursing and Rest Homes Only)

Part 2. DIRECTOR OF NURSES

This schedule should be completed if the management company/central office employs a Director of Nurses who works directly at the nursing home. The schedule is not for the manager or the person to whom the Director of Nurses reports. This should be carried forward to Part 1, column G. The total for each facility should equal the HCF-3 DON Add-back (9962.3) on the HCF-1.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9323.3) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | TOTAL | DON's Name |
|  |  | $ | $ | $ | $ | $ |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Part 3(a). DIETICIAN.

This schedule should be completed if the management company/central office employs or has a contract with the dietician who works directly at the nursing home. It should not be filled out with the expenses of a manager of a dietician or the person to whom a dietician reports. The total for each facility should equal the HCF-3 Dietician Add-back (9967.0) on the HCF-1/HCF-4.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9323.4) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | Contract Service | TOTAL |
|  |  | $ | $ | $ | $ | $ | $ |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

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Part 3(b). INDIRECT THERAPY SALARIES

This schedule should be completed if the management company/central office employs or has a contract with a Physical Therapist, Occupational Therapist or Speech Therapist who performs the indirect services directly at the

nursing home. This schedule should not contain expenses of a manager of a therapist or a person to whom a therapist reports. The total for each facility should equal the HCF-3 Indirect Restorative Add-back (9968.0) on the HCF-1.

THIS SCHEDULE SHOULD NOT INCLUDE THE COSTS OF DIRECT THERAPY SERVICES AS DEFINED PER REGULATION 101 CMR 206.00. Direct Therapy expenses are non-allowable and should not be allocated to the HCF-1.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9323.5) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | Contract Service | TOTAL |
|  |  | $ | $ | $ | $ | $ |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Part 3(c). QUALITY ASSURANCE PROFESSIONAL

This schedule should be completed if the management company/central office employs or has a contract with a Quality Assurance Professional who works directly at the nursing home. This schedule should not

contain expenses of a manager of a Quality Assurance Professional or a person to whom a Quality Assurance Professional reports. The total for each facility should equal the HCF-3 QA Professional Add-back (9969.0)

on the HCF-1.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9323.1) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | Contract Service | TOTAL |
|  |  | $ | $ | $ | $ | $ |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

The sum of Part 3, a, b and c are carried forward to column F, Part 1.

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Part 4(a). ADMINISTRATORS-IN-TRAINING

This schedule should be completed if the management company/central office employs or has a contract with an Administrator in-Training who works directly at the nursing home or rest home. This schedule should not contain expenses of a manager of an Administrator-in-Training or a person to whom the Administrator-in-Training reports. The total for each facility should equal the HCF-3 Administrator-in-Training Add-back (9971.0) on the HCF-1.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9313.1) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | TOTAL | Administrator-in-Training's  Name |
|  |  | $ | $ | $ | $ | $ |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Part 4(b). ADMINISTRATOR

This schedule should be completed if the management company/central office employs or has a contract with an Administrator who works directly at the nursing home or rest home. This schedule should not contain expenses of a manager of an Administrator or a person to whom the Administrator reports. The total for each facility should equal the HCF-3 Administrator Add-back (9972.0) on the HCF-1.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name | VPN | Salary (9314.1) | Payroll Taxes | Health \ Life Ins.  & Pension | Workers’ Compensation | TOTAL | Administrator's Name |
|  |  | $ | $ | $ | $ | $ |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

The sum of Part 4, a and b are carried forward to column D, Part 1.

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NOTE: The HCF-3 serves the dual purpose of a report of the financial condition and a claim statement for reimbursement. Schedules 13 and 14 should be used to convert the amount reported in the financial statements into a total requested for reimbursement.

SCHEDULE 13: DETAIL OF AUTOMATICALLY DISALLOWED EXPENSES

Schedule 13 lists expense categories which the Center automatically disallows. This schedule is included in the report as an informational tool for the facility administrator.

|  |  |  |
| --- | --- | --- |
| Account # | Amount | Account Name |
| (9316.1) |  | Officer/Owner Compensation |
| (9317.3) |  | Directors' Fees |
| (9321.0) |  | Other Management Fees |
| (9323.6) |  | Direct Restorative Therapies |
| (9332.6) |  | Telephone Directory Advertising |
| (9336.5) |  | Motor Vehicle Expense |
| (9342.6) |  | Other Advertising |
| (9351.7) |  | Group Life/Health & Life Insurance & Pension - Officer/Owner/Dir. |
| (9361.3) |  | Accounting Appeal Services |
| (9366.3) |  | Legal Appeal Services |
| (9367.7) |  | Other Legal Services |
| (9371.3) |  | Payroll Taxes - Officer/Owner/Director |
| (9373.1) |  | Workers’ Compensation - Officer/Owner/Director |
| (9381.5) |  | Interest on Late Payments, Penalties |
| (9381.7) |  | Interest on Working Capital |
| (9301.4) |  | TOTAL AUTOMATIC DISALLOWED |

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SCHEDULE 14: DETAIL OF SELF DISALLOWED EXPENSES

Schedule 14 provides the detail of expenses reported within the financial statements, not claimed by the facility for reimbursement. This may involve only some of the expenses in a particular account category (i.e. partial clerical expenses or partial office supplies expenses). This section should be used to report any non-allowable expenses other than those reported on Schedule 13. Partial values of accounts are appropriate here. Payroll taxes and benefits related to positions whose salaries are non-allowable must be reported here. (NOTE: The basis used for determining the amount should be given in Schedule 14a.)

This schedule may not be used to add-back costs of other departments or offices.

Account # Amount Account Name

A & G EXPENSES

|  |  |  |
| --- | --- | --- |
| (3650.4) |  | A & G Recoverable Income |
| (9312.1) |  | Administration Salaries |
| (9313.1) |  | Administrator-in-Training |
| (9314.1) |  | Administrator |
| (9321.1) |  | Clerical Services |
| (9322.3) |  | Payroll Services/EDP |
| (9323.7) |  | Other Administrative Costs |
| (9325.0) |  | Office Supplies |
| (9331.5) |  | Phone(s) |
| (9338.6) |  | Conventions & Meetings |
| (9339.6) |  | Other Travel |
| (9341.5) |  | Advertising - Help Wanted |
| (9345.0) |  | Licenses and Dues |
| (9351.6) |  | Group Life/Health Insurance & Pensions - Administration |
| (9351.4) |  | Group Life/Health Insurance & Pensions - Other A & G Employees |
| (9362.7) |  | Other Accounting Services |
| (9371.2) |  | Payroll Taxes - Administration |
| (9371.4) |  | Payroll Taxes - Other A & G Employees |
| (9377.3) |  | General Insurance |
| (9376.2) |  | Workers’ Compensation – Administration |
| (9373.4) |  | Workers’ Compensation - Other A & G Employees |

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SCHEDULE 14 continued

|  |  |  |
| --- | --- | --- |
| (9379.0) |  | Miscellaneous Expenses |
| (9390.0) |  | Maintenance |
| (9391.0) |  | Other Property Costs |
| (9301.5) |  | TOTAL A & G |

VARIABLE EXPENSES

|  |  |  |
| --- | --- | --- |
| (3650.5) |  | Variable Recoverable Income |
| (9323.1) |  | Quality Assurance Professionals |
| (9323.5) |  | Indirect Restorative Therapy |
| (9323.4) |  | Dietitian |
| (9351.5) |  | Group Life/Health Insurance & Pensions – Variable Employees |
| (9371.5) |  | Payroll Taxes - Variable Employees |
| (9373.5) |  | Workers’ Compensation - Variable Employees |
| (9301.6) |  | TOTAL VARIABLE |

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FIXED EXPENSES

(3650.3)

Fixed Recoverable Income

(9380.0)

Real Estate Taxes

(9380.1)

Personal Property Taxes

(9380.5)

Insurance - Building, Building Improvements, Equipment

(9381.0)

Interest

(9382.0)

Rent

(9386.8)

Depreciation - Building

(9387.8)

Depreciation - Improvements

(9387.9)

Depreciation - HCF Capitalization Improvements

(9388.8)

Depreciation - Equipment

(9388.9)

Depreciation - HCF Capitalization Equipment

(9390.8)

Depreciation - Software/Ltd. Life Assets\*

(9390.9)

Depreciation - HCF Capitalization Software/Ltd. Life Assets\*

(9301.1)

TOTAL FIXED EXPENSES

\*See Instructions

2020 HCF-3 Page 25

SCHEDULE 14a

This sheet should be used to explain the basis for determining the amounts disallowed in

Schedule 14.

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Management Company/Central Office Name

Balance Sheet Date (MO-DA-YR)

2020 HCF-3

SCHEDULE 15: DETAIL OF CLAIMED FIXED COSTS

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Allowable Basis or  Cost of Beg. Yr.1 | Claimed  Additions | Claimed  Deletions2 | Allowable Basis or  Cost End. of Year | Rate% | Depreciation HCF-3 | From HCF-2 (If Applicable) |
| Land HCF-3 |  |  | ( ) |  | XXX | XXXXX | XXXXX |
| Land HCF-2 |  |  | ( ) |  | XXX | XXXXX | XXXXX |
| Building HCF-3 |  |  | ( ) |  | 2.5 |  | XXXXX |
| Building HCF-2 |  |  | ( ) |  | 2.5 | XXXXX |  |
| Improvements HCF-3 |  |  | ( ) |  | 5.0 |  | XXXXX |
| Improvements HCF-2 |  |  | ( ) |  | 5.0 | XXXXX |  |
| HCF Cap. Improv. HCF-3 |  |  | ( ) |  | 5.0 |  | XXXXX |
| HCF Cap. Improv. HCF-2 |  |  | ( ) |  | 5.0 | XXXXX |  |
| Equipment HCF-3 |  |  | ( ) |  | 10.0 |  | XXXXX |
| Equipment HCF-2 |  |  | ( ) |  | 10.0 | XXXXX |  |
| HCF Cap. Equip. HCF-3 |  |  | ( ) |  | 10.0 |  | XXXXX |
| HCF Cap. Equip. HCF-2 |  |  | ( ) |  | 10.0 | XXXXX |  |
| Software/Ltd. Life \* HCF-3 |  |  | ( ) |  | 33.3 |  | XXXXX |
| Software/Ltd. Life\* HCF-2 |  |  | ( ) |  | 33.3 | XXXXX |  |
| HCF Cap. Software/Ltd. Life Assets\* HCF-3 |  |  | ( ) |  | 33.3 |  | XXXXX |
| HCF Cap. Software/Ltd. Life Assets\* HCF-2 |  |  | ( ) |  | 33.3 | XXXXX |  |
| Long-Term Int. Claimed\* | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| MA Corp. Excise Tax Non-Income Portion | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| Building Insurance | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| Real Estate Taxes | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| Personal Property Taxes | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| Other (Explain in Footnotes) (4538.8) | XXXXX | XXXXX | XXXXX | XXXXX | XXX |  |  |
| HCF-3 Fixed Cost Recoverable Income |  |  |  |  |  | ( ) | ( ) |
| TOTAL FIXED COSTS CLAIMED (A) + (B) HCF-3 & HCF-2 (Post to Page 19) | | | | | | (A) (9302.1)3, 4 | (B) (9302.9) 4 |

The Center’s automatic adjustment process will disallow all fixed costs such as deprecation, mortgage interest, real estate taxes (account

9300.1). This schedule should be

used to claim those fixed costs which will be considered in the reimbursement of the facility’s capital. Preparers of this schedule should carefully review regulation

101 CMR 206.00. Incorrect reporting could seriously delay the setting of rates.

1. Allowable basis is the portion of assets used for public patient care.

2. Deletions include retired, sold,

written off, damaged, and fully depreciated assets.

3. Adult Day Care costs should be removed from this schedule.

Explain method of allocation on pg. 6 in the Footnotes and Explanations section of this report.

4. HCF-3 Claimed Fixed Expenses should be claimed in account

9302.1 on page 14. HCF-2 Fixed

Expenses should be added back in account 9302.9 on page 14.

\* See Instructions.

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SCHEDULE 16: DETAIL OF CLERICAL SALARIES EXPENSE

Please provide a description of the Clerical Salaries expense. The total must agree with the amount claimed in account (9321.1) as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name | Job Title | Brief Job Description | 2020  Gross  Salary |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | | (9321.1) |

SCHEDULE 17: DETAIL OF ADMINISTRATION SALARIES EXPENSE

Please provide a description of the Administration Salaries expense. The total must agree with the amount claimed in account (9312.1) as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name | Job Title | Brief Job Description | 2020  Gross  Salary |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | | (9312.1) |

SCHEDULE 19: DETAIL OF OTHER ADMINISTRATIVE COSTS

Provide below details of the expenses claimed in Other Administrative account (9323.7).

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name | Date Incurred  (MO-DA-YR) | Amount | Brief Description of Expense |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | (9323.7) |  |

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SCHEDULE 20: DETAIL OF GENERAL INSURANCE

Provide below details of the expenses claimed in General Insurance account (9377.3).

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name | Date Incurred  (MO-DA-YR) | Amount | Brief Description of Expense |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | (9377.3) |  |

SCHEDULE 21: DETAIL OF MISCELLANEOUS EXPENSES

Provide below details of the expenses claimed in Miscellaneous Expenses account (9379.0).

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name | Date Incurred  (MO-DA-YR) | Amount | Brief Description of Expense |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | (9379.0) |  |

SCHEDULE 22: DETAIL OF OTHER PROPERTY COSTS

Provide below details of the expenses claimed in Other Property account (9391.0).

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor Name | Date Incurred  (MO-DA-YR) | Amount | Brief Description of Expense |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | (9391.0) |  |

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SCHEDULE 23: ORGANIZATIONAL STRUCTURE (in effect this cost report year)

1. Supply the Center with a macro organizational chart of your complete business structure.

2. Shade in each component of your organizational chart from which costs are allocated to your

Massachusetts Nursing Home Facilities.

3. Describe the basis used to allocate costs from each shaded component of your organizational chart to your Massachusetts Nursing/Rest Home Facilities. Support your narrative with actual dollar values.

(See Sample Response in the Instructions for an example.)

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SCHEDULE 24: ADDITIONAL INFORMATION Part 1.

Provide below a brief history of your organization. As part of your description, include the date the company came into existence and the dates of any notable structural changes.

Part 2.

Supply below the name of a person who may be contacted for clarification and/or additional information concerning the information presented in Schedule 23 and Schedule 24.

Contact Person

Telephone #

Best Time to Call

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