

THE COMMONWEALTH OF MASSACHUSETTS
CENTER FOR HEALTH INFORMATION AND ANALYSIS
501 BOYLSTON STREET
BOSTON, MASSACHUSETTS 02116-4704

2020 HCF-4
RESIDENT CARE FACILITIES REPORT

Batch # _____

1a. VPN 5501571

1b. Provider ID / MMIS# 100062890A

2. Balance Sheet Date 12/31/2020
(MO-DAY-YR)

3. Name of Facility HOME FOR AGED WOMEN IN SALEM , INC.
D/B/A BROOKHOUSE HOME FOR AGED WOMEN

Street Address 180 DERBY STREET

City SALEM Zip 01970

4. Telephone (978) 744-0219 Fax (978) 744-1516
Area Code - Number Area Code - Number

5. Name of Administrative/Responsible Person Judy Kane

Federal Employer Identification Number 04-2104318

Responsible Person 's Affiliation (*Write O, R, or U) U

* O - Officer R - Related to Owner U - Unrelated Employee

6. Legal Status and Form Status: Profit _____ Non-Profit X Form (Enter 1-9) 3

1. MA Corp - Chapter 156B 5. Sole Proprietorship

2. MA Corp - Chapter 156B with a 501 c.3 tax exemption 6. Governmental Entities

3. MA Corp - Chapter 180 7. Other For-Profit

4. Partnership 8. Other Non-Profit

9. Non MA Corp

7. Other Business Activities (Enter Y = Yes or N = No) N

Child Day Care N Assisted Living N

Adult Day Care N Other(Explain) N

8. Has the facility had a change in long - term care financing in 2020?
(Enter Y = Yes or N = No) N

9. (a) Are you submitting an HCF-2-RH (Realty Company Report)? (Enter Y=Yes or N=No) N

(b) Are you managed by a Management company? Enter Y=Yes or N=No N

If yes, enter name _____ and Comb# _____

Are you submitting an HCF-3 ? Enter Y=Yes or N=No _____

10. Has an extension been granted for this cost report submission?
(Enter Y=Yes or N=No) Y If yes, attach a copy of the approved extension letter.

11 Contact Information:

Name: Jonathan Langfield Phone: 617-984-8100

Address: 300 Crown Colony Drive, Suite 310, Quincy, MA 02184

Email Address: jonathan.langfield@CLAconnect.com

The HCF-4 serves the dual purpose of being a report to the Center by providers that accurately reflects the complete financial condition of the facility and is, at the same time, a claim for reimbursement. To accomplish the latter, on Schedule 2, after Total Operating Expenses, lines have been provided to report Total Non-Allowable Expenses, which are itemized on Schedule 13 and 14. When reporting these expenses, providers must indicate which are "ordinary and necessary" from a generally-accepted accounting or Internal Revenue standpoint, and which are not directly related to the care of publicly-aided patients and not reimbursable under current regulations. It is expected that the signers and preparers of this form are familiar with the regulations and reimbursement formula.

- 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.
- Failure to file timely will result in sanctions as prescribed under regulation 101 CMR 204.07(7).

THIS REPORT IS DUE: JUNE 4, 2021.

For assistance in completing this form, call the Help Desk at (617) 701-8297.

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:

HOME FOR AGED WOMEN IN SALEM, INC. 5501571
Provider Name Vendor Payment Number
for the Cost Report period beginning 1/1/2020 and ending 12/31/2020

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 the person other than owner, partner, or officer, this declaration is based on all information of which he/she has any knowledge.

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

Name of Owner, Partner, or Officer

Crane

Last Name

Thomas

First Name

Officer

Title

m M.I. Email Address TomCrane77@gmail.com

6/2/2021

Date of Signature (MO-DA-YR)

Thomas M. Crane

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 Name CliftonLarsonAllen LLP

Preparer's Name _____

Preparer's Title Certified Public Accountants

Preparer's Address 300 Crown Colony Drive, Suite 310, Quincy, MA 02169

Phone Number (617) 984-8100 Email Address jonathan.langfield@CLAconnect.com

6/2/2021

Date of Signature (MO-DA-YR)

Signature of Preparer other than Owner, Partner or Officer

Type of Accounting Service Performed O¹

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

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

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HOME FOR AGED WOMEN IN SALEM , INC. 5501571
Provider Name Vendor Payment Number
for the Cost Report period beginning 1/1/2020 and ending 12/31/2020

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 the person other than owner, partner, or officer, this declaration is based on all information of which he/she has any knowledge.

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

Name of Owner, Partner, or Officer

Last Name

Email Address

First Name

M.I.

Officer

6/4/2021

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 Name CliftonLarsonAllen LLP

Preparer's Name _____

Preparer's Title Certified Public Accountants

Preparer's Address 300 Crown Colony Drive, Suite 310, Quincy, MA 02169

Phone Number (617) 984-8100 Email Address jonathan.langfield@CLAconnect.com

6/4/2021

Date of Signature (MO-DA-YR)

CliftonLarsonAllen LLP

Signature of Preparer other than Owner, Partner or Officer

Type of Accounting Service Performed 0¹

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

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-4 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 facility. If the facility is owned by a corporation or chain, list the name of the corporation under "Last Name". If the facility is held under a trust, the beneficial owner(s) must be identified under "Last Name".

Last Name	First Name	MI	Address	Percentage Ownership	Direct or Indirect
HOME FOR AGED WOMEN IN SALEM, INC.			180 DERBY STREET, SALEM, MA	100	DIRECT

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

Nursing and/or 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 facility 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 facility.

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	Markup	Cost	Account Posted	Name of Owner	% Ownership
SEE ATTACHMENT							

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: Thomas M. Crane

TITLE: Officer

DATE: 6/4/21

SIGNATURE: _____

TITLE: _____

DATE: _____

SIGNATURE: _____

TITLE: _____

DATE: _____

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

First Name

Title

Account	#2530.0 ¹	# 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

Partnership:

Last Name

First Name

Title

Circle one:
Owner / Officer / Partner

Account	#2540.0 ¹	#	#	#	#
% Time Devoted					
Salary	\$ XXX	\$	\$	\$	\$
Employee Benefits	\$ XXX	\$	\$	\$	\$
Payroll Taxes	\$ XXX	\$	\$	\$	\$
Workers' Comp.	\$ XXX	\$	\$	\$	\$
Gr. Life/Health Ins.	\$ XXX	\$	\$	\$	\$
Draw	\$	\$	\$	\$	\$
Other:	\$ XXX	\$	\$	\$	\$
Total	\$	\$	\$	\$	\$

Last Name

First Name

Title

Circle one:
Owner / Officer / Partner

Account	#2540.0 ¹	#	#	#	#
% Time Devoted					
Salary	\$ XXX	\$	\$	\$	\$
Employee Benefits	\$ XXX	\$	\$	\$	\$
Payroll Taxes	\$ XXX	\$	\$	\$	\$
Workers' Comp.	\$ XXX	\$	\$	\$	\$
Gr. Life/Health Ins.	\$ XXX	\$	\$	\$	\$
Draw	\$	\$	\$	\$	\$
Other:	\$ XXX	\$	\$	\$	\$
Total	\$	\$	\$	\$	\$

Corporation:

Crane

Last Name

Tom

First Name

Title

Circle one:
Owner / Officer / Partner

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

Last Name

First Name

Title

Circle one:
Owner / Officer / Partner

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

Last Name

First Name

Title

Circle one:
Owner / Officer / Partner

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

¹Annual Draw or Earnings Distribution.

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.

	(a+b+c+d)	(a)	(b)	(c)	(d)
Kane	Account	Total	#4110.1	#	#
Last Name	% Time Devoted	100%	100%	%	%
Judith	Salary	\$ 114,350	\$ 114,350	\$	\$
First Name	Employee Benefits	\$	\$	\$	\$
Administrator	Payroll Taxes	\$ 8,748	\$ 8,748	\$	\$
Title	Workers' Comp.	\$ 229	\$ 229	\$	\$
	Gr. Life/Health Ins.	\$ 3,024	\$ 3,024	\$	\$
	Draw	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
	Total	\$ 126,351	\$ 126,351	\$	\$

(7710.1)

	(a+b+c+d)	(a)	(b)	(c)	(d)
Coffin	Account	Total	#5105.1	#	#
Last Name	% Time Devoted	100%	100%	%	%
Julia	Salary	\$ 70,535	\$ 70,535	\$	\$
First Name	Employee Benefits	\$	\$	\$	\$
Maintenance	Payroll Taxes	\$ 5,396	\$ 5,396	\$	\$
Title	Workers' Comp.	\$ 1,411	\$ 1,411	\$	\$
	Gr. Life/Health Ins.	\$	\$	\$	\$
	Draw	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
	Total	\$ 77,342	\$ 77,342	\$	\$

(7711.1)

	(a+b+c+d)	(a)	(b)	(c)	(d)
Marsha	Account	Total	#7021.1	#	#
Last Name	% Time Devoted	100%	100%	%	%
DiCesare	Salary	\$ 53,149	\$ 53,149	\$	\$
First Name	Employee Benefits	\$	\$	\$	\$
Activities	Payroll Taxes	\$ 4,066	\$ 4,066	\$	\$
Title	Workers' Comp.	\$ 1,063	\$ 1,063	\$	\$
	Gr. Life/Health Ins.	\$ 9,084	\$ 9,084	\$	\$
	Draw	\$	\$	\$	\$
	Other:	\$	\$	\$	\$
	Total	\$ 67,362	\$ 67,362	\$	\$

(7712.1)

GENERAL INFORMATION

1. Licensed Bed Allocation on 12/31/20 per Public Health

Level IV

Geriatric Beds 36

1a. Indicate Constructed Capacity 36

2. Has there been a change in licensed beds during the year?

Yes No X

2a. If yes, indicate the dates of changes.

Table with 2 columns: Date From, Date To

3. Date of purchase by current owner (MO-DA-YR). 1861

4. If the facility is rented, list the name and address of the owners: If rent is paid, file an HCF-2-RH.

Name: Street Address: City, State, Zip:

5. Has there been any change in ownership during 2020?

Yes No X

5a. If yes, indicate date (MO-DA-YR).

5b. Purchased from : (Name)

5c. Purchased by: (Name)

5d. Has a Change of Ownership form been filed?

Yes No X

6. Have any Capitalized Leases been presented on the Balance Sheet?

If Yes, a liability should be recorded on Schedule 5.

Yes No X

7. Does this report contain any accrued expenses which have been either unpaid or unfunded such as, for example, pension costs, self insured workers' compensation, or any other self insured expenses? If Yes, the unpaid or unfunded portions should be self-disallowed on Schedule 14.

Yes No X

8. Does this report and claim for reimbursement include any amounts for services of non-paid workers as provided for in 101 CMR 204.04(6)(g)? If yes, provide a schedule of amounts and account numbers on the Footnotes and Explanations section and attach a copy of the required agreement if not previously submitted.

Yes No X

9. Have you reported any individual's salary in more than one account, i.e., cost splitting? If so, explain on the Footnotes and Explanations section, giving method of allocation, amount and account numbers.

Yes No X

10. Except for accruals made pursuant to FASB-43, i.e. vacation and sick time earned but not yet paid, do all accruals represent expenses incurred only during the current reporting period? If No, provide details and explanations on the Footnotes and Explanations section.

Yes X No

Licensed beds during the year

1. Licensed Bed Allocation on 12/31/20 per Public Health

Geriatric Beds 36

1a. Indicate Constructed Capacity 36

2. **Summary of Change in licensed beds during the year**

LICENSED BEDS: 12/31/20

<u>FROM</u>	<u>TO:</u>	<u># DAYS</u>	<u>LEVEL IV</u>	<u>LEVEL IV</u>
1/1/2020	12/31/2020	366	36	13,176
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
TOTAL LICENSED		366	36	13,176

CONSTRUCTED BEDS:

<u>FROM</u>	<u>TO:</u>	<u># DAYS</u>	<u>LEVEL IV</u>	<u>LEVEL IV</u>
1/1/2020	12/31/2020	366	36	13,176
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
1/1/2018	12/31/2017			
TOTAL CONSTRUCTED BEDS		366	36	13,176

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.

SEE ATTACHED

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

ASSETS

Current Assets

Cash

Checking Account	(1020.0)	<u>487,430</u>
On Hand	(1030.0)	<u>1,992</u>
Temporary Investments	(1040.0)	<u> </u>
Other	(1050.0)	<u> </u>

Total Cash (1010.0) 489,422

Accounts Receivable

Private Patients	(1080.0)	<u> </u>
Publicly-Aided		
- MA LV IV (Billed)	(1100.2)	<u>9,587</u>
- MA Comm. for the Blind LV IV	(1104.1)	<u> </u>
- VA & Other Public	(1101.2)	<u> </u>
Reserve for Bad Debts	(1140.0)	<u>()</u>

Total Accounts Receivables (1060.0) 9,587

Loans Receivable

Officers/Owner	(1160.0)	<u> </u>
Employees	(1170.0)	<u> </u>
Affiliates / Related Parties	(1180.0)	<u> </u>
Other Loans Receivable	(1185.0)	<u> </u>

Total Loans Receivable (1150.0)

Interest Receivable (1190.0)

Supply Inventory (1210.0)

Prepaid Expenses

Prepaid Interest	(1270.0)	<u> </u>
Prepaid Insurance	(1280.0)	<u>14,448</u>
Prepaid Taxes	(1290.0)	<u> </u>
Capitalized Pre-Opening Costs*	(1295.0)	<u> </u>
Other Prepaid Expenses*	(1300.0)	<u>2,541</u>

Total Prepaid Expenses (1260.0) 16,989

Other Current Assets (1310.0)

Total Current Assets (1005.0) 515,998

* See Instructions

Fixed Assets

Land

Cost	(1511.1)	<u>16,657</u>	
Book Value			(1510.0) <u>16,657</u>

Building

Cost	(1521.1)	<u>90,532</u>	
Accum. Depr.	(1522.2)	<u>(90,532)</u>	
Book Value			(1520.0) _____

Building Improvements

Cost	(1611.1)	<u>1,464,915</u>	
Accum. Depr.	(1612.2)	<u>(723,719)</u>	
Book Value			(1610.0) <u>741,196</u>

Leasehold Improvements

Cost	(1626.1)	_____	
Accum. Depr.	(1627.2)	<u>()</u>	
Book Value			(1625.0) _____

Other Improvements

Cost	(1631.1)	<u>35,190</u>	
Accum. Depr.	(1632.2)	<u>(15,534)</u>	
Book Value			(1630.0) <u>19,656</u>

HCF Capitalization - Improvements

Cost	(1616.1)	_____	
Accum. Depr.	(1617.2)	<u>()</u>	
Book Value			(1615.0) _____

Equipment

Cost	(1651.1)	<u>162,922</u>	
Accum. Depr.	(1652.2)	<u>(129,778)</u>	
Book Value			(1650.0) <u>33,144</u>

HCF Capitalization - Equipment

Cost	(1661.1)	_____	
Accum. Depr.	(1662.2)	<u>()</u>	
Book Value			(1660.0) _____

Motor Vehicles

Cost	(1701.1)	_____	
Accum. Depr.	(1702.2)	<u>()</u>	
Book Value			(1700.0) _____

Software/Limited Life Assets

Cost	(1710.1)	<u>39,227</u>	
Accum. Depr.	(1710.2)	<u>(39,767)</u>	
Book Value			(1710.0) <u>(540)</u>

HCF Capitalization - Software/Limited Life Assets

Cost	(1715.1)	_____	
Accum. Depr.	(1715.2)	<u>()</u>	
Book Value			(1715.0) _____

Fully Depreciated Building ¹		
Cost	(1731.1)	_____
Accum. Depr.	(1732.1)	(_____)
Book Value		(1733.1) _____
Fully Depreciated Building Improvements ¹		
Cost	(1731.2)	_____
Accum. Depr.	(1732.2)	(_____)
Book Value		(1733.2) _____
Fully Amortized Leasehold Improvements ¹		
Cost	(1734.1)	_____
Accum. Depr.	(1734.2)	(_____)
Book Value		(1734.0) _____
Fully Depreciated Other Improvements ¹		
Cost	(1735.1)	_____
Accum. Depr.	(1735.2)	(_____)
Book Value		(1735.0) _____
Fully Depreciated HCF Cap. Improvements ¹		
Cost	(1736.1)	_____
Accum. Depr.	(1736.2)	(_____)
Book Value		(1736.0) _____
Fully Depreciated Equipment ¹		
Cost	(1731.3)	_____
Accum. Depr.	(1732.3)	(_____)
Book Value		(1733.3) _____
Fully Depreciated HCF Cap. Equipment ¹		
Cost	(1731.7)	_____
Accum. Depr.	(1732.7)	(_____)
Book Value		(1733.7) _____
Fully Depreciated Motor Vehicle ¹		
Cost	(1731.4)	_____
Accum. Depr.	(1732.4)	(_____)
Book Value		(1733.4) _____
Fully Depreciated Software/Ltd. Life Assets ¹		
Cost	(1731.5)	_____
Accum. Depr.	(1732.5)	(_____)
Book Value		(1733.5) _____
Fully Depreciated HCF Cap. Software/Ltd. Life Assets ¹		
Cost	(1731.6)	_____
Accum. Depr.	(1732.6)	(_____)
Book Value		(1733.6) _____
Total Fixed Assets		(1500.0) 810,113

¹ Only report assets that are fully depreciated. Assets that are sold, damaged or suffering other losses should not be reported here. Appropriate entries should be made to reflect these deletions (i.e. Accumulated Depreciation).

Deferred Charges and Other Assets

Organization Expense	(1910.0)	_____	
Purchased Goodwill	(1940.0)	_____	
Leasehold Deposits	(1950.0)	_____	
Utility Deposits	(1960.0)	_____	
Cash Surrender Value of Officer Life Insur.	(1970.0)	_____	
Mortgage Acq. Cost *	(1975.1)	_____	
Accumulated Amort. of Mort. Acq. Cost	(1975.2)	(_____)	
Unamortized Mort. Acq. Cost	(1975.0)	_____	
Construction in Progress *	(1979.0)	17,000	
Other ¹	(1980.0)	4,154,500	
Total Deferred Charges and other Assets	(1900.0)		4,171,500
<u>TOTAL ASSETS</u>	(1000.0)		5,497,611

* See Instructions

¹Provide description of Other on the Footnotes and Explantations section of this report.

LIABILITIES AND NET WORTH

Current Liabilities

Accounts Payable

Trade	(2020.0)	<u>10,579</u>
Accrued Expenses	(2030.0)	<u>28,455</u>
Due Comm. of Mass.	(2047.0)	<u>37,400</u>

Total Accounts Payable (2010.0) 76,434

Patients Fund Due (2050.0) 70

Notes and Loans Payable (See Schedule 5)

Officer, Owner or Related Parties	(2110.0)	_____
Subsidiaries & Affiliates	(2120.0)	_____
Banks	(2130.0)	_____
Motor Vehicles	(2140.0)	_____
Other Short-Term Financing	(2150.0)	<u>156,937</u>
Payments Due Within One Year on Long-Term Debt *	(2160.0)	_____

Total Notes and Loans Payable (2100.0) 156,937

Accrued Salaries & Payroll Liabilities

Accrued Salaries	(2190.0)	<u>19,272</u>
Accr. Payroll Tax W/held	(2200.0)	_____
Accr. Employee Taxes Pay.	(2210.0)	<u>2,228</u>
Other Payroll Liabilities	(2220.0)	<u>1,825</u>

Total Accrued Salaries & Payroll Liabilities (2180.0) 23,325

Other Current Liabilities

Accr. St. & Fed. Taxes	(2260.0)	_____
Accrued Interest Payable	(2270.0)	_____
Other Current Liabilities	(2290.0)	<u>31,944</u>

Total Other Current Liabilities (2250.0) 31,944

Total Current Liabilities

(2005.0) 288,710

Long-Term Liabilities (See Schedule 5)

Mortgages*	(2310.0)	_____
Other Long Term Debt *	(2320.0)	_____

Total Long-Term Liabilities

(2300.0) _____

*See Instructions

Net Worth

Proprietorship or Partnership

Capital	(2520.0)	_____
Proprietor Drawings	(2530.0)	(_____)
Partnership Drawings	(2540.0)	(_____)
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)	<u>5,208,901</u>

Total Corporation (2610.0) 5,208,901

Total Net Worth (2500.0) 5,208,901

TOTAL LIABILITIES AND NET WORTH (2000.0) 5,497,611

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

GROSS INCOME

Private	(3021.1)	<u>118,341</u>
DTA	(3022.5)	<u>1,201,146</u>
MA DTA Patient Resource Income	(3022.6)	_____
Non-MA DTA	(3022.7)	_____
MA Commission for the Blind	(3023.1)	_____
VA and Other Public	(3023.2)	_____
Adult Day Care Income	(3025.3)	_____
Other Non-Nursing Income	(3026.2)	_____
Ancillary Services (Itemize related expenses below)		
Private	(3031.1)	_____
Medicaid (DMA)	(3032.5)	_____
Non-MA Medicaid	(3032.7)	_____
MA Commission for the Blind	(3033.1)	_____
VA & Other Public	(3033.2)	_____
Total Ancillary Services	(3030.0)	_____
Miscellaneous and Recoverable Income		
Endowment & Other Nonrecoverable ¹	(3120.0)	<u>813,935</u>
Laundry	(3140.0)	_____
Vending Machines	(3150.0)	_____
Bad Debt Recovery	(3160.0)	_____
Prior Year Retroactive	(3170.0)	_____
Interest Income	(3180.0)	_____
Operating Costs Recoverable	(3194.0)	<u>1,349</u>
Fixed Costs Recoverable	(3196.0)	_____
Total Miscellaneous and Recoverable Income	(3130.0)	<u>815,284</u>
<u>TOTAL GROSS INCOME</u>	(3000.0)	<u>2,134,771</u>

Key Entry - Do not key below this line

Ancillary Expenses relating to above Ancillary Income (Also Post to Schedule 14 if appropriate)

Account #	Expense Classification	Amount

¹ Explain on the Footnotes and Explanations section of this report.

OPERATING EXPENSES

Administrative

Administrative/Responsible Person Salaries (4110.1) 114,350

Officer Salaries* (4125.1) _____

Other

Clerical Salaries ¹ (4140.1) 49,344

EDP/Payroll/Bkkpg. Serv. (4150.3) 13,022

Mgmt. Fees (See HCF-3) (4160.3) _____

Management Consultants * (4160.6) _____

Total Other (4130.1) 62,366

Total Administrative (4100.0) 176,716

General Supplies & Expenses

Office Supplies (4250.5) 17,914

Telephone

Phone (4261.5) 6,572

Directory Advertising (4262.6) _____

Total Telephone (4260.0) 6,572

Travel

Motor Vehicle Expense * (4275.5) _____

Conventions and Meetings (4280.5) 700

Total Travel (4270.5) 700

Advertising

Help Wanted (4295.7) 9,319

Promotional (4298.7) 5,101

Total Advertising (4290.0) 14,420

Licenses and Dues

Pt. Care Related Portion (4301.7) 3,120

Promo., Goodwill & Leg. Port. (4302.3) _____

Total Licenses and Dues (4300.0) 3,120

Education and Training

Staff Dev. Coord. Salary (4306.1) _____

Administration (4306.2) _____

Other Required Education (4306.3) _____

Job Related Education (4306.4) _____

Total Education and Training (4305.0) _____

* See Instructions

¹ Provide Description of Clerical Expenses (4140.1) on Sch. 16.

Employee Benefits

Employee Benefits - Pensions ¹	(4310.1)	_____
Employee Benefits - Other	(4310.2)	<u>5,133</u>
Off.-Profit-Sharing & Bfts-Oth.	(4339.2)	_____
Total Employee Benefits	(4310.0)	<u>5,133</u>

Accounting

Appeal Service	(4350.3)	_____
Other ²	(4360.3)	<u>28,455</u>
Total Accounting	(4340.0)	<u>28,455</u>

Legal

Appeal Service	(4380.3)	_____
D.A.L.A. - Filing Fees	(4385.7)	_____
Other Legal	(4390.7)	_____
Total Legal	(4370.0)	_____

Payroll Taxes

Payroll Taxes - Other	(4411.1)	<u>85,267</u>
Payroll Taxes-Officers	(4411.2)	_____
Total Payroll Taxes	(4400.0)	<u>85,267</u>

Insurance

Nonprofit DES Claims	(4428.7)	_____
Malpractice and General Liability*	(4431.7)	<u>22,796</u>
Keyman Insurance	(4432.7)	_____
Bldg., Impr. & Equip.	(4590.8)	<u>10,924</u>

Workers' Compensation

Workers' Comp - Other	(4424.1)	<u>9,737</u>
Workers' Comp-Officers	(4424.2)	_____

Group Life / Health

Group Life/Health - Other	(4426.1)	<u>13,926</u>
Group Life/Health - Officers	(4426.2)	_____

Total Insurance	(4420.0)	<u>57,383</u>
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* See Instructions

¹ Description of Pension Plan on the Footnotes and Explanations section of this report.

² Provide Description of other Accounting Expenses (4360.3) on Schedule 17.

Provide

Interest on Late Payments, Penalties	(4415.0)	_____
Interest on Working Cap. ¹	(4430.0)	_____
Pre-Opening Expenses *	(4435.0)	_____

Other Expenses - Description Required

Description	Amount
_____	_____
_____	_____
_____	_____
_____	_____

Total Other Operating Expenses	(4443.0)	1,353
--------------------------------	----------	--------------

Total General Supplies and Expenses	(4200.0)	220,317
-------------------------------------	----------	----------------

Fixed Costs

Real Estate Taxes	(4510.8)	_____
Personal Property Taxes *	(4515.8)	_____
Interest Long-Term ²	(4520.8)	_____
Rent - Real Property ³ (HCF-2-RH Required)	(4535.8)	_____
Other (Explain below)	(4538.8)	_____

Item	Expense
Equipment Rental 0	
Other (Explain) 0	
Other (Explain) 0	
Total Other (4538.8)	

Depreciation - Building	(4550.8)	_____
Depreciation - Bldg Improvements	(4565.8)	54,670
Depreciation - HCF Cap. Improvements	(4566.8)	_____
Amortization - Leasehold Improvements	(4567.8)	_____
Depreciation - Other Improvements	(4568.8)	_____
Depreciation - Equipment	(4570.8)	10,435
Depreciation - HCF Cap. Equipment	(4576.8)	_____
Depreciation - Software/Limited Life Assets	(4585.8)	_____
Depreciation - HCF Cap. Software/Limited Life Assets	(4586.8)	_____

Total Fixed Costs	(4540.0)	65,105
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* See Instructions

¹ See Schedule 5, Part 2.

² See Schedule 5, Part 1.

³ If rent expense is for less than a full year, please explain.

Plant Operation, Maintenance & Security		
Salaries	(5105.1)	<u>70,535</u>
Purchased Service	(5110.3)	<u>36,751</u>
Supplies and Expenses	(5115.5)	<u>8,333</u>
Utilities	(5120.5)	<u>44,606</u>
Repairs	(5130.7)	<u> </u>
Total Plant Operation, Maintenance & Security	(5100.0)	<u>160,225</u>
Dietary		
Salaries	(5205.1)	<u>141,056</u>
Food	(5220.5)	<u>73,035</u>
Purchased Service	(5221.3)	<u>118,645</u>
Dietitian - Salary	(5231.1)	<u> </u>
Dietitian - Purchased Service	(5233.3)	<u>1,313</u>
Supplies and Expenses	(5235.5)	<u>3,058</u>
Total Dietary	(5200.0)	<u>337,107</u>
Laundry		
Salaries	(5310.1)	<u>35,306</u>
Purchased Service	(5320.3)	<u> </u>
Supplies and Expenses	(5330.5)	<u>627</u>
Linen and Bedding	(5340.5)	<u> </u>
Total Laundry	(5300.0)	<u>35,933</u>
Housekeeping		
Salaries	(5410.1)	<u>55,032</u>
Purchased Service	(5415.3)	<u>178</u>
Supplies and Expenses	(5420.5)	<u>10,745</u>
Total Housekeeping	(5400.0)	<u>65,955</u>
Nursing		
Registered Nurses		
Salaries	(6030.1)	<u>44,520</u>
RN Purchased Service	(6035.3)	<u> </u>
Licensed Practical Nurses		
Salaries	(6041.1)	<u> </u>
LPN Purchased Service	(6042.3)	<u> </u>
Nurses' Aides		
Salaries	(6051.1)	<u>404,678</u>
NA Purchased Service	(6052.3)	<u> </u>
Total Nursing	(6000.0)	<u>449,198</u>

Medical Services

Quality Assurance Professional (6504.1) _____
 Community Support Coordinator (6507.1) _____

Physicians' Services

Employee Physicals (6514.3) _____
 Other (Explain) (6515.3) _____
 Total Physicians' Services (6510.0) _____

Medical Supplies & Drugs

Legend Drugs (6520.5) _____
 House Sup. Not Resold (6522.5) **47,062** _____
 Resold to Private Patients (6523.5) _____
 Total Medical Supplies and Drugs (6520.0) **47,062** _____
 Pharmacy Consultant (6530.0) _____
 Social Service Worker (6540.0) _____

Total Medical Services (6500.0) **47,062** _____

Restorative & Recreational Therapy

Restorative Therapy

Indirect Salaries* (7011.1) _____
 Direct Salaries * (7012.1) _____
 Direct Benefits * (7012.2) _____
 Indirect Consultants (7013.3) _____
 Direct Consultants (7014.3) _____
 Total Restorative Therapy (7010.0) _____

Recreational Therapy

Salaries (7021.1) **60,602** _____
 Purchased Service (7022.3) _____
 Supplies and Expense (7023.5) **10,444** _____
 Transportation (7024.8) _____
 Total Recreational Therapy (7020.0) **71,046** _____

Total Restorative & Recreational Therapy (7000.0) **71,046** _____

Bad Accts.-Taxes-Refunds-Day Care

Bad Accounts (8010.0) _____
 Fines, Late Charges, and Penalties (8015.0) _____
 State and Federal Income Taxes (8025.5) _____
 Mass. Excise Tax (Tangible Portion) (8027.7) _____
 Refunds and Allowances (8030.0) _____
 Adult Day Care Costs * (8040.0) _____
 Other Non-Nursing Costs* (8065.0) _____

Total Bad Accts.-Taxes-Refunds-Day Care (8000.0) _____
 *See Instructions

TOTAL OPERATING EXPENSES (4000.0) **1,628,664**

Less Non-Allowable Expenses

Schedule 13 Automatically Disallowed	(9939.0)	<u>82,479</u>
Schedule 14 Self-Disallowed	(9945.0)	<u>54,571</u>
Total Non-Allowable Expenses	(4001.1)	(<u>137,050</u>)

Plus Additional Claimed Operating Expenses

Schedule 15 Claimed Fixed Costs	(9950.0)	<u>92,156</u>
HCF-2-RH Other Operating Add-Back (HCF-2-RH, Sch. 4)	(9502.2)	_____
HCF-3 ALLOCATED A & G (HCF-3, Sch. 10)	(9960.3)	_____
HCF-3 ALLOCATED Fixed Cost (HCF-3, Sch. 10)	(9961.3)	_____
HCF-3 Dietitian, etc. (HCF-3, Sch. 10, part 3)	(9963.3)	_____
Total Additional Claimed Operating Expenses	(4001.2)	<u>92,156</u>

TOTAL ALLOWABLE OPERATING EXPENSES CLAIMED (4002.0) **1,583,770**

Have you reported any costs on this HCF-4 that come directly from the management company, in addition to what has been allocated through Schedule 10 of the HCF-3?

Circle Yes or No: Yes _____ No **N**

If Yes, explain in detail in the Footnotes and Explanations section of this report giving the account(s) and the dollar amount(s) of the entry.

SCHEDULE 3: RESIDENT DAY INFORMATION

JANUARY 1, 2020 - MARCH 31, 2020

DTA (Massachusetts Only)			
Resident Care	(0210.5)	<u>2,789</u>	
Total DTA			(0210.0) <u>2,789</u>
Massachusetts EAEDC			
Resident Care	(0212.5)	_____	
Massachusetts EAEDC			(0212.0) _____
Non-Massachusetts DTA			
Resident Care	(0215.4)	_____	
Total Non-Massachusetts DTA			(0215.0) _____
MA Commission for the Blind			
Resident Care	(0260.5)	_____	
Total MA Commission for the Blind			(0260.0) _____
Veterans Administration and Other Public ¹			
Resident Care	(0270.5)	_____	
Total VA and Other Public			(0270.0) _____
Private			
Resident Care	(0290.5)	<u>213</u>	
Total Private			(0290.0) <u>213</u>
<u>TOTAL RESIDENT DAYS: JANUARY 1, 2020 - MARCH 31, 2020</u>			(0200.0) <u>3,002</u>

APRIL 1, 2020 - JUNE 30, 2020

DTA (Massachusetts Only)			
Resident Care	(0310.5)	<u>2,529</u>	
Total DTA			(0310.0) <u>2,529</u>
Massachusetts EAEDC			
Resident Care	(0312.5)	_____	
Massachusetts EAEDC			(0312.0) _____
Non-Massachusetts DTA			
Resident Care	(0315.4)	_____	
Total Non-Massachusetts DTA			(0315.0) _____
MA Commission for the Blind			
Resident Care	(0360.5)	_____	
Total MA Commission for the Blind			(0360.0) _____
Veterans Administration and Other Public ¹			
Resident Care	(0370.5)	_____	
Total VA and Other Public			(0370.0) _____
Private			
Resident Care	(0390.5)	<u>182</u>	
Total Private			(0390.0) <u>182</u>
<u>TOTAL RESIDENT DAYS: APRIL 1, 2020 - JUNE 30, 2020</u>			(0300.0) <u>2,711</u>

¹ Identify Other Public Payers in detail on the Footnotes & Explanations section of this report as explained in Instructions
2020 HCF-4 Page 20

JULY 1, 2020 - SEPTEMBER 30, 2020

DTA (Massachusetts Only)		
Resident Care	(0410.5) <u>2,500</u>	
Total DTA		(0410.0) <u>2,500</u>
Massachusetts EAEDC		
Resident Care	(0412.5) _____	
Massachusetts EAEDC		(0412.0) _____
Non-Massachusetts DTA		
Resident Care	(0415.4) _____	
Total Non-Massachusetts DTA		(0415.0) _____
MA Commission for the Blind		
Resident Care	(0460.5) _____	
Total MA Commission for the Blind		(0460.0) _____
Veterans Administration and Other Public ¹		
Resident Care	(0470.5) _____	
Total VA and Other Public		(0470.0) _____
Private		
Resident Care	(0490.5) <u>184</u>	
Total Private		(0490.0) <u>184</u>
<u>TOTAL RESIDENT DAYS: JULY 1, 2020 - SEPTEMBER 30, 2020</u>		(0400.0) <u>2,684</u>

OCTOBER 1, 2020 - DECEMBER 31, 2020

DTA (Massachusetts Only)		
Resident Care	(0510.5) <u>2,598</u>	
Total DTA		(0510.0) <u>2,598</u>
Massachusetts EAEDC		
Resident Care	(0512.5) _____	
Massachusetts EAEDC		(0512.0) _____
Non-Massachusetts DTA		
Resident Care	(0515.4) _____	
Total Non-Massachusetts DTA		(0515.0) _____
MA Commission for the Blind		
Resident Care	(0560.5) _____	
Total MA Commission for the Blind		(0560.0) _____
Veterans Administration and Other Public ¹		
Resident Care	(0570.5) _____	
Total VA and Other Public		(0570.0) _____
Private		
Resident Care	(0590.5) <u>92</u>	
Total Private		(0590.0) <u>92</u>
<u>TOTAL RESIDENT DAYS: OCTOBER 1, 2020 - DECEMBER 31, 2020</u>		(0500.0) <u>2,690</u>

<u>TOTAL RESIDENT DAYS - ENTIRE YEAR</u>		(0100.0) <u>11,087</u>
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¹ Identify Other Public Payers in detail on the Footnotes & Explanations section of this report as explained in Instructions
2020 HCF-4- Page 21

NUMBER OF ADMISSIONS DURING 2020	(0140.0) <u> 2</u>
NUMBER OF DISCHARGES DURING 2020	(0150.0) <u> 4</u>
NUMBER OF PUBLIC COMMUNITY SUPPORT ADMISSIONS- 2020	(0170.0) <u> </u>
NUMBER OF TOTAL COMMUNITY SUPPORT ADMISSIONS- 2020	(0175.0) <u> </u>
2020 PUBLIC COMMUNITY SUPPORT RESIDENT DAYS	(0180.0) <u> </u>
2020 PRIVATE COMMUNITY SUPPORT RESIDENT DAYS	(0182.0) <u> </u>
TOTAL COMMUNITY SUPPORT RESIDENT DAYS - 2020	(0185.0) <u> </u>

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-Day-Yr	Due Date Mo-Day-Yr	No. of Months Amort.	Monthly Payments	Original Mortgage Amount	Mort. Acq. Costs	Amort. of Mort. Acq. Costs	Bal. 01/01/2020	Principal Payment	Bal. 12/31/2020	Rate %	Interest Expense	Period Expense*
1st Mortgage															
2nd Mortgage															
3rd Mortgage															
4th Mortgage															
Chattel Note															
Chattel Note															
Capital Lease															
See Attached															
Totals	XXXXXXX	XXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX			XXXXXXXX	XXXXXXXX		XXXXXX		

(a)

(b)

(c)

* See Instructions

Total Fixed Interest a + b + c (4520.8)=

\$ _____

2. Working Capital Debt ¹

	Lender Name	Rel. Party Y/N	Balance 01/01/2020	New Loan Amount	Start Mo-Day-Yr	Principal Payment	Balance 12/31/2020	Interest Rate %	Interest Expense ²
1	SBA PPP Loan	N		156,937	2020		156,937		
2									
3									

Total Working Capital Interest (4430.0)²= \$ _____

Total Working Capital Debt (2100.0 less 2160.0) = \$ **156,937**

¹ This 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 a new line separately.

² The sum of the working capital interest expense.

SCHEDULE 5: ANALYSIS OF MORTGAGES AND NOTES PAYABLE

SCHEDULE 5: ANALYSIS OF MORTGAGES AND NOTES PAYABLE (cont)

1. Mortgages and Notes Supporting Fixed Assets (cont.)¹

	Lender Name	Rel. Party Y/N	Date Mort. Acquired Mo-Day-Yr	Due Date Mo-Day-Yr	No. of Months Amort.	Monthly Payments	Original Mortgage Amount	Mort. Acq. Costs	Amort. of Mort. Acq. Costs	Bal. 01/01/2020	Principal Payment	Bal. 12/31/2020	Rate %	Interest Expense	Period Expense*
Chattel Note															
Chattel Note															
Capital Lease															
Capital Lease															
Capital Lease															
Capital Lease															
Capital Lease															
Totals	XXXXXXXXXXXXXXXX	XXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX				a				XXXXX	b	c

2. Working Capital Debt (cont)¹

#	Lender Name	Rel. Party Y/N	Balance 01/01/2020	New Loan Amount	Start Mo-Day-Yr	Principal Payment	Balance 12/31/2020	Interest Rate %	Interest Expense ^
3									
4									
5									
6									
7									
8									

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

Total Income Per Report (Account # 3000.0)	<u>\$ 2,134,771</u>
Total Operating Expenses (Account # 4000.0)	<u>\$ 1,628,664</u>
HCF-4 Net Income (Loss) before reconciling items	<u><u>\$ 506,107</u></u> 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	<u>\$</u>
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<u>NET INCOME (LOSS) PER BOOKS</u>	<u><u>\$ 506,107</u></u> ²
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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.

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-4 Net Income (Loss) Sch. 7	_____	
5. Drawing during year	(_____)	
6. Balance 12/31/2020 (2500.0)	_____	3

DO NOT CHANGE ANY HEADING NAMES BELOW

CORPORATION

	Capital Stock (2620.0)	Additional Paid-In (2630.0)	Retained Earnings (2650.0)	Treasury Stock (2640.0)	Total (2500.0)
1. Balance 12/31/2019 ¹	_____	_____	4,702,794	_____	4,702,794 ¹
2. Other: Prior Period Adjustments: ²	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	_____	xxxxxxxxxxxxx	_____ ²
3. Sale of Stock	_____	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxx	_____
4. Additional Paid-In Capital	xxxxxxxxxxxxxxxxxxx	_____	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxx	_____
5. HCF-4 Net Income (Loss) Sch 7	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	506,107	xxxxxxxxxxxxx	506,107
6. Dividends Paid	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	(_____)	xxxxxxxxxxxxx	(_____)
7. Treasury Stock Purchased/Sold	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxx	_____	_____
8. Balance 12/31/2020 ³	_____	_____	5,208,901	_____	5,208,901 ³
	(2620.0)	(2630.0)	(2650.0)	(2640.0)	(2500.0)

¹ This amount should agree with acct. #2500.0, Total Net Worth, page 12, on the 2019 HCF-4.

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 12, 2020 HCF-4. Detail explanation for any difference.

NOTE: The HCF-4 serves the dual purpose of a report of the financial condition and a claim statement for reimbursement. Schedule 13 and 14 should be used to convert the amount reported in the financial statements into a claim 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
3150.0		Vending Machines Income
3194.0	1,349	Recoverable Operating Costs
3196.0		Recoverable Fixed Costs
4125.1		Officers Salaries & Directors' Fees
4160.3		Management Fees
4160.6		Management Consultants
4262.6		Telephone Directory Advertising
4298.7	5,101	Advertising - Promotional
4302.3		Licenses & Dues: Promotion, Goodwill & Legislative Portion
4339.2		Officer - Profit Sharing & Benefits - Other
4350.3		Accounting - Appeal
4380.3		Legal Appeal
4385.7		Div. of Administrative Law (DALA) - Filing Fees
4390.7		Other Legal
4411.2		Payroll Taxes - Officer
4415.0		Interest on Late Payments, Penalties
4424.2		Workers' Compensation - Officer
4426.2		Group Life / Health - Officer
4430.0		Working Capital Interest
4432.7		Keyman Insurance
4435.0		Pre-Opening Expenses
4510.8		Real Estate Taxes
4515.8		Personal Property Taxes
4520.8		Interest - Long Term
4535.8		Rent - Real Property Affiliate
4538.8		Other Rent
4550.8		Building - Depreciation
4565.8	54,670	Building Improvement - Depreciation
4566.8		HCF Capitalization - Improvement - Depreciation
4567.8		Leasehold Improvement - Depreciation
4568.8		Other Improvements - Depreciation
4570.8	10,435	Equipment - Depreciation
4576.8		HCF Capitalization - Equipment - Depreciation
4585.8		Software/Limited Life Assets - Depreciation
4586.8		HCF Capitalization - Software/Limited Life - Depreciation
4590.8	10,924	Insurance - Building, Improvements & Equipment
6520.5		Medical Supplies & Drugs - Legend Drugs
6523.5		Resold to Private Patients
7012.1		Restorative Therapy - Direct Salaries
7012.2		Restorative Therapy - Direct Benefits
7014.3		Restorative Therapy - Direct Consultants
7024.8		Recreation Therapy - Transportation
8010.0		Bad Accounts - Taxes - Refunds - Day Care
8015.0		Bad Accounts - Fines - Late Charges - Penalties
8025.5		Massachusetts and Federal Income Taxes
8027.7		Massachusetts Excise Tax - Total
8030.0		Refunds and Allowances
8040.0		Adult Day Care Costs
8065.0		Other Non-Nursing Facility Costs
(9939.0)	82,479	TOTAL AUTOMATIC ADJUSTMENTS (Enter this amount page 19)

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 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: HCF-2-RH and HCF-3 Add Backs should be reported on page 19.)

<u>Acct#</u>	<u>Amount</u>	<u>Account Name</u>
4110.1		Responsible Person's Salary
4140.1	49,344	Clerical Salaries
4150.3		EDP/Payroll/Bookkeeping Services
4250.5		Office Supplies
4261.5		Telephone
4275.5		Motor Vehicle Expenses
4280.5		Conventions and Meetings
4295.7		Advertising - Help Wanted
4301.7		Licenses & Dues (Patient Care Related Portion)
4306.1		Staff Development Coordinator Salary
4306.2		Administration Education and Training
4306.3		Other Required Education
4306.4		Job Related Education
4310.1		Employee Benefits - Pensions
4310.2		Employee Benefits - Other
4360.3		Other Accounting
4411.1	3,775	Payroll Taxes - Other
4424.1	99	Workers' Compensation - Other
4426.1		Group Life/Health - Other
4428.7		NonProfit DES Claims
4431.7		Malpractice / General Liability Insurance
4443.0	1,353	Other Operating Expenses
5105.1		Maintenance Salaries
5110.3		Maintenance Purchased Service
5115.5		Maintenance Supplies & Expenses
5120.5		Maintenance - Utilities
5130.7		Maintenance - Repairs
5205.1		Dietary - Salaries

<u>Acct#</u>	<u>Amount</u>	<u>Account Name</u>
5220.5		Dietary - Food
5221.3		Dietary Purchased Service
5231.1		Dietician Salary
5233.3		Dietician Purchased Service
5235.5		Dietary - Supplies & Expense
5310.1		Laundry - Salary
5320.3		Laundry - Purchased Service
5330.5		Laundry - Supplies
5340.5		Laundry - Linen & Bedding
5410.1		Housekeeping - Salary
5415.3		Housekeeping - Purchased Service
5420.5		Housekeeping - Supplies
6030.1		RN Salaries
6035.3		RN Purchased Service
6041.1		LPN Salaries
6042.3		LPN Purchased Service
6051.1		NA Salaries
6052.3		NA Purchased Service
6504.1		Quality Assurance Professional
6507.1		Community Support Coordinator
6514.3		Employee Physicals
6515.3		Other Physicians' Services
6522.5		House Supplies Not Resold
6530.0		Pharmacy Consultant
6540.0		Social Service Worker
7011.1		Indirect Restorative Therapy - Salaries
7013.3		Indirect Restorative Therapy - Consultants
7021.1		Recreational Therapy - Salaries
7022.3		Recreational Therapy - Purchased Service
7023.5		Recreational Therapy - Supplies & Expense
(9945.0)	54,571	<u>TOTAL SELF-DISALLOWED</u>

SCHEDULE 15: DETAIL OF CLAIMED FIXED COSTS

The Center's automatic adjustment process will disallow all fixed costs such as depreciation, mortgage interest, real estate taxes (Account 4540.0). 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 204.00. 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.

* See Instructions

	Allowable Basis or Cost Beg. Yr. ¹	Claimed Additions	Claimed Deletions ²	Allowable Basis or Cost End of Yr.	Rate %	Depreciation HCF-4	From HCF-2-RH (If Applicable)	
Land HCF-4	16,657		()	16,657	XXX	XXXXXXXX	XXXXXXXX	
Land HCF-2-RH			()		XXX	XXXXXXXX	XXXXXXXX	
Building HCF-4	90,532		()	90,532	2.5		XXXXXXXX	
Building HCF-2-RH			()		2.5	XXXXXXXX		
Improvements HCF-4	1,400,479	99,626	()	1,500,105	5.0	72,996	XXXXXXXX	
Improvements HCF-2-RH			()		5.0	XXXXXXXX		
HCF Cap. Improv. HCF-4			()		5.0		XXXXXXXX	
HCF Cap. Improv. HCF-2-RH			()		5.0	XXXXXXXX		
Equipment HCF-4	151,759	11,163	()	162,922	10.0	8,236	XXXXXXXX	
Equipment HCF-2-RH			()		10.0	XXXXXXXX		
HCF Cap. Equip. HCF-4			()		10.0		XXXXXXXX	
HCF Cap. Equip. HCF-2-RH			()		10.0	XXXXXXXX		
Software/Limited Life* HCF-4	39,227		()	39,227	33.3		XXXXXXXX	
Software/Limited Life* HCF-2-RH			()		33.3	XXXXXXXX		
HCF Cap. Software/Ltd. Life Assets* HCF-4			()		33.3		XXXXXXXX	
HCF Cap. Software/Ltd. Life Assets* HCF-2			()		33.3	XXXXXXXX		
Long-Term Int. Claimed *	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX			
MA Corp. Excise Tax Non-Income Portion	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX			
Building Insurance	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX	10,924		
Real Estate Taxes	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX			
Personal Property Taxes	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX			
Other (Explain in footnotes) (4538.8)	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX			
HCF-4 Fixed Costs Recoverable Income								
SUBTOTALS	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXX	(A) 92,156	(B)	
TOTAL FIXED COSTS CLAIMED	HCF-4 AND HCF-2-RH (Post to Page 19) (A+B)						\$ 92,156	(9500.0) ³

SCHEDULE 16: DETAIL OF CLERICAL EXPENSES (4140.1)

Please provide a description of the Clerical expense.

The total must agree with the amount claimed in account (4140.1) on page 14.

Employee Name	Job Title	Brief Job Description	2020 Gross Salary
SEE ATTACHED			49,344
TOTAL			49,344 (4140.1)

SCHEDULE 17: DETAIL OF OTHER ACCOUNTING (4360.3)

Provide description of Accounting Expenses claimed in account 4360.3 by using the codes provided below:

Part 1: Purchased Service Accounting

Vendor Name	Date Incurred (MO-DA-YR)	Amount	Code	Brief Description of Expense
CliftonLarsonAllen, LLP	2020	1,050	A	HCF Preparation
CliftonLarsonAllen, LLP	2020	25,305	F	Audit
CliftonLarsonAllen, LLP	2020	1,850	C	Corporate Tax Prep.
CliftonLarsonAllen, LLP	2020	250	H	Annual Report & Form 3ABC
SUBTOTAL (Part 1)		\$ 28,455		

Codes: Type of service / responsibilities

A. HCF-4 Prep.	D. Personal Tax Prep.	G. SEC Filings
B. Medicare Cost Rpt. Prep.	E. Mgmt. Advisory Serv.	H. Other Allow. Acct. - Explain
C. Corporate Tax Prep.	F. Certified Audit	I. Other Non-Allow Acct. - Explain

Part 2: Employee's Responsibilities Only

Employee Name	Job Title	Salary	Description of Responsibilities with code and % allocation of time
SUBTOTAL (Part 2)		\$	

TOTAL ACCOUNTING (Part 1 + Part 2)	\$ 28,455 (4360.3)	
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SCHEDULE 29: DETAIL OF EMPLOYEE WAGES AND BENEFITS

PART 1

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)						
Positions	Number of FTE's* (round to one decimal place)	Number of Staff	Total Hours	Total Salaries	Group Life/ Health Benefits	Pensions	Other Benefits						
Staff Development	(7110.2)		(7210.2)	(7310.2)	(4306.1)	(7410.2)	(7510.2)	(7610.2)					
Maintenance Staff	(7111.2)	1.0	(7211.2)	1	(7311.2)	2,091	(5105.1)	70,535	(7411.2)	1,007	(7511.2)	(7611.2)	371
Dietary Staff	(7112.2)	3.4	(7212.2)	11	(7312.2)	6,984	(5205.1)	141,056	(7412.2)	2,014	(7512.2)	(7612.2)	742
Dietician	(7113.2)		(7213.2)		(7313.2)		(5231.1)		(7413.2)		(7513.2)	(7613.2)	
Laundry Staff	(7114.2)	1.0	(7214.2)	1	(7314.2)	2,112	(5310.1)	35,306	(7414.2)	504	(7514.2)	(7614.2)	186
Housekeeping Staff	(7115.2)	1.8	(7215.2)	2	(7315.2)	3,739	(5410.1)	55,032	(7415.2)	786	(7515.2)	(7615.2)	290
Quality Assurance	(7116.2)		(7216.2)		(7316.2)		(6504.1)		(7416.2)		(7516.2)	(7616.2)	
Community Support Coord.	(7119.2)		(7219.2)		(7319.2)		(6507.1)		(7419.2)		(7519.2)	(7619.2)	
Social Service Staff	(7120.2)		(7220.2)		(7320.2)		(6540.0)		(7420.2)		(7520.2)	(7620.2)	
Restorative - Indirect Salaries	(7121.2)		(7221.2)		(7321.2)		(7011.1)		(7421.2)		(7521.2)	(7621.2)	
Restorative - Direct Salaries	(7122.2)		(7222.2)		(7322.2)		(7012.1)		(7422.2)		(7522.2)	(7622.2)	
Recreational Staff	(7123.2)	1.3	(7223.2)	3	(7323.2)	2649	(7021.1)	60,602	(7423.2)	865	(7523.2)	(7623.2)	319

* See Instructions

SCHEDULE 29: DETAIL OF EMPLOYEE WAGES AND BENEFITS

PART 2

(1) Positions	(2) Number of FTE's* (round to one decimal place)	(3) Number of Staff	(4) Total Hours	(5) Total Salaries	(6) Group Life/ Health Benefits	(7) Pensions	(8) Other Benefits
Administrator	(7124.2) 1.0	(7224.2) 1	(7324.2) 2,080	(4110.1) 114,350	(7424.2) 1,633	(7524.2)	(7624.2) 602
Officer	(7125.2)	(7225.2)	(7325.2)	(4125.1)	(4426.2)	(7525.2)	(7625.2)
Clerical Staff	(7126.2) 0.8	(7226.2) 1	(7326.2) 1,580	(4140.1) 49,344	(7426.2) 704	(7526.2)	(7626.2) 260
RN's	(7129.2) 1.0	(7229.2) 1	(7329.2) 2,080	(6030.1) 44,520	(7429.2) 636	(7529.2)	(7629.2) 234
LPN's	(7130.2)	(7230.2)	(7330.2)	(6041.1)	(7430.2)	(7530.2)	(7630.2)
Nurses Aides	(7131.2) 10.2	(7231.2) 15	(7331.2) 21216	(6051.1) 404678	(7431.2) 5,777	(7531.2)	(7631.2) 2,130

* See Instructions

ATTACHMENTS TO HCF COST REPORT

THE FOLLOWING SCHEDULES ARE PART OF THE HCF-4 SUBMISSION

HCF
PAGE

REF	SCHEDULE NAME	# OF PAGES
3	RELATED PARTY LIST.	1
6	FOOTNOTES & DISCLOSURES	4
29	DETAIL OF CLERICAL EXPENSES (4140.1)	1

FOOTNOTES AND EXPLANATIONS

Page 5 - General Information - Non-Paid Workers #8

The following accounts includes amounts for services of non-paid workers per regulation 114.2 CMR 4.00.

HCF Acct. #	Amount	Description of Services
_____	_____	_____
_____	_____	_____
_____	_____	_____

Page 5 - General Information - Cost Splitting #9

The following accounts include costs associated with cost splitting:

Description	HCF Acct. #	Amount	HCF Acct. #	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
TOTAL		=====		=====

Method of allocation: _____

Schedule 1 - Other Assets (1980.0)

Acct. Title	Amount
Investments	4,154,500
_____	_____
_____	_____
_____	_____
Total (1980.0)	4,154,500

Schedule 2 - Endowment & Other Non-recoverable Income (3120.0)

Acct. Title	Amount
Donations/Grants	130,739
Investment Income/Gain/Loss	564,219
Total COVID-19 Payments	118,977
Total (3120.0)	813,935

Facility Name: HOME FOR AGED WOMEN IN SALEM, INC. VPN 5501571

Balance Sheet Date (mo-da-yr) 12/31/2020

FOOTNOTES AND EXPLANATIONS

Schedule 2 - Pension Expense (4310.1)

Brief Description of Plan:

Schedule 2 - Rent Real Property (4535.8)

If rent expense is for less than a full year, explain:

Period: From _____ To _____

Schedule 2 - Direct Management Company Expenses

The following accounts reflect a direct allocation of expense from the management company:

HCF Acct. #	Amount	Explanation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Schedule 3 Resident Day Information

Other Public Patient Days as follows:

Qtr.	Type of Contract	# of Patients	Patient Days
1st.			
2nd.			
3rd			
4th			

Schedule 8 - Prior Period Adjustments

Brief Description and impact on any Reimbursable Account, if any.
