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

2025 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/HCF-2 RH 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/HCF-2 RH. 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:

May 12, 2026 WHEN FILED WITH THE HCF-4/HCF-2 COST REPORT.

For assistance in completing this form, email Costreports.LTCF@chiamass.gov.

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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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

_____ Email Address _____
First Name M.I.

_____ _____
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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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 206.00 & 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 and/or resident care facility in which the owners listed in item #1 own, directly or indirectly, an interest of 5% or more.

Nursing and/or Resident Care Facility	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 12/31/2025	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 12/31/2025	Name of Owner

5. Indicate any entity, person or related party as defined in REGULATION 101 CMR 206.00 & 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: _____

Management Company/Central Office Name ______________________________

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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:

____
Last Name

____
First Name

____
Title
Owner / Officer / Partner

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

____
Last Name

____
First Name

____
Title
Owner / Officer / Partner

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

____
Last Name

____
First Name

____
Title
Owner / Officer / Partner

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

[1]Annual Draw or Earnings Distribution

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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

_____
First Name

_____
Title

	(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	$	$	$	$	$

(7710.1)

_____
Last Name

_____
First Name

_____
Title

	(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	$	$	$	$	$

(7711.1)

_____
Last Name

_____
First Name

_____
Title

	(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	$	$	$	$	$

(7712.1)

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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-4/2 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.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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

Land

Cost	(1511.1) _____	
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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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/Limited Life Assets			
Cost	(1715.1) _____		
Accum. Depr.	(1715.2) (_____)		
Book Value		(1715.0) _____	
Total Fixed Assets			(1500.0) _____

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)	
Other[1]		(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/i 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.

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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 2: STATEMENT OF PROFIT AND LOSS (For Year Ending December 31, 2025)

INCOME

Nursing 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 Salaries[3]	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)		
Clerical[1]	A & G	(9321.1)		
Payroll Service/EDP	A & G	(9322.3)		
Other[2]	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)		
Director of Nursing	D	(9323.3)		
Total Other Administrative, Variable & DON 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.

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)	_____	
Director of Nursing	D	(9352.0)	_____	
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)	_____	
Director of Nursing	D	(9372.0)	_____	
Total Payroll Taxes				(9370.0) _____
Insurance				
General[1]	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)	_____	
Director of Nursing	D	(9374.0)	_____	
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.

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 Costs[1]	A & G	(9391.0)	_____

Total Expenses are summarized on the next page.

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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

The accounts below summarize reported expenses and non-allowable costs by cost center.

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 Director of Nursing Expenses*	D	(9300.8) _____	
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 Self Disallowed Dir. Nurs. (Sch. 14)	D	(9301.8) _____	
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 Director of Nursing Expenses (9300.8 less 9301.8)	D	(9302.8) _____	
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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 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. 1/1/2025	Principal Payment	Bal. 12/31/2025	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

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

2. Working Capital Debt

#	Lender Name	Rel.Party Y/N	Balance 1/1/2025	Amount	Start Mo-Da-Yr	Principal Payment	Balance 12/31/2025	Interest Rate %	Interest Expense[2]
1									
2									
3									

Total Working Capital Interest (9381.7)[2] = $_____

Total Working Capital Debt (2100.0 less 2160.0) = $_____

[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 new line separately.
[2]The sum of the working capital interest expense.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

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.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 8: RECONCILIATION OF NET WORTH

PROPRIETORSHIP AND PARTNERSHIP

1.	Balance 12/31/2018 (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 12/31/2025 (2500.0)	_____ [3]

CORPORATION

DO NOT CHANGE ANY HEADING NAMES BELOW

	Capital Stock (2620.0)	Additional Paid-In (2630.0)	Retained Earnings (2650.0)	Treasury Stock (2640.0)	Total (2500.0)
1. Balance 12/31/2018 [1]	_____	_____	_____	_____	_____ [1]
2. Other: Prior Period Adjustments:[2]	xxxxxxxxxxxx	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	xxxxxxxxxxxxx	_____	_____
8. Balance 12/31/2025 [3]	_____ (2620.0)	_____ (2630.0)	_____ (2650.0)	_____ (2640.0)	_____ [3] (2500.0)

1. This amount should agree with acct. #2500.0 , Total Net Worth, page 9, on 2018 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 2025 HCF-3. Detail explanation for any difference.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 10: MANAGEMENT COMPANY/CENTRAL OFFICE EXPENSE ALLOCATION

Part 1: Provide allocation to Massachusetts Nursing and Resident Care Facilities, Non-Mass Nursing and Resident Care Facilities 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 Services[2]	(C) = A + B Total HCF-3 A & G Add-back	(D) Direct A & G (Admin.-in-Training & Administrators[1]) (from Part 4)	(E) HCF-2-NH Other Operating Add-back[3]		(F) Direct Variable (Dietician, Indirect Therapy & QA[1]) (from Part 3)	(G) Direct Dir. of Nurses[1] (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 Resident Care Facilities 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-4/HCF-2. Total Fixed Expenses must equal the Fixed Cost add-back claimed on HCF-4/HCF-2.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 10: DIRECT ALLOCATION ONLY (Massachusetts Nursing and Resident Care Facilities 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.

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-4/HCF-2.

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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 10: DIRECT ALLOCATION ONLY (Massachusetts Nursing and Resident Care Facilities Only)

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.

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.

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.

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.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 10: DIRECT ALLOCATION ONLY (Massachusetts Nursing and Resident Care Facilities Only)

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. This schedule should not contain expenses of a manager of an Administrator-in-Training or a person to whom the Administrator-in-Training reports.

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. This schedule should not contain expenses of a manager of an Administrator or a person to whom the Administrator reports.

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.

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**

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

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**

DIRECTOR OF NURSING EXPENSES

(3650.2) _____ DON Recoverable Income

(9323.3) _____ Director of Nursing

(9352.0) _____ Group Health Insurance

(9372.0) _____ Payroll Taxes

(9374.0) _____ Workers' Compensation

(9301.8) _____ **TOTAL DIRECTOR OF NURSING**

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

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 14a

This sheet should be used to explain the basis for determining the amounts disallowed in Schedule 14.

Management Company/Central Office Name _____

Balance Sheet Date (MO-DA-YR) _____ _____ _____ 2025 HCF-3

SCHEDULE 15: DETAIL OF CLAIMED FIXED COSTS

	Allowable Basis or Cost of Beg. Yr.[1]	Claimed Additions	Claimed Deletions[2]	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.

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	2025 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	2025 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)	

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)	

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/Resident Care Facilities. Support your narrative with actual dollar values.

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

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 _____