THE COMMONWEALTH OF MASSACHUSETTS CENTER FOR HEALTH INFORMATION AND ANALYSIS

501 BOYLSTON STREET BOSTON, MASSACHUSETTS 02116

1a. VPN

1b. Provider ID / MMIS #

2. Balance Sheet Date

2020 HCF-4

RESIDENT CARE FACILITY REPORT

(MO-DA-YR)

Batch #

3. Name of Facility

Street Address

City

Zip

4. Telephone ( ) Fax ( ) Area Code - Number Area Code - Number

5. Name of Administrative/Responsible Person Federal Employer Identification Number Responsible Person's Affiliation (\*Write O, R, or U)

\* O - Officer R - Related To Owner U - Unrelated Employee

6. Legal Status and Form Status: Profit

Non-Profit

Form (Enter 1 – 9)

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)

Child Day Care

Adult Day Care

Assisted Living

Other (Explain)

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

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

If yes, enter name

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

and Comb #

10. Has an extension been granted for this cost report submission?

(Enter Y = Yes or N = No) If yes, attach a copy of the approved extension letter.

11. Contact Information:

Name:

Phone:

Address:

Email Address:

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 Schedules 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, email the Help Desk at [CHIAcostreports.LTCF@state.ma.us.](mailto:CHIAcostreports.LTCF@state.ma.us)

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 Vendor Payment 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 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

First Name M.I.

Email Address

Title Date of Signature (MO-DA-YR)

Signature of Owner, Partner or Officer

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

Name of Preparer other than Owner, Partner or Officer

Firm 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

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 | Percent  Ownership | Direct or  Indirect |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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 | 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:

PROPRIETORSHIP, PARTNERSHIP OR CORPORATE INFORMATION

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

Sole Proprietorship:

Last Name

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

First Name

Title

Partnership:

Last Name

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

First Name

Title Circle one:

Owner / Officer / Partner

Last Name

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

First Name

Title Circle one:

Owner / Officer / Partner

Corporation:

Last Name

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

First Name

Title Circle one:

Owner / Officer / Partner

Last Name

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

First Name

Title Circle one:

Owner / Officer / Partner

Last Name

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

First Name

Title Circle one:

Owner / Officer / Partner

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.

Last Name

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

First Name

Title

(7710.1)

Last Name

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

First Name

Title

(7711.1)

Last Name

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

First Name

Title

(7712.1)

GENERAL INFORMATION

1. Licensed Bed Allocation on 12/31/2020 per Public Health

Level IV

Geriatric Beds

1a. Indicate Constructed Capacity

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

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

Date Date

From To

Yes No

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

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

Name:

Street Address:

City, State, Zip

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

Yes No

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

5b. Purchased from: (Name)

5c. Purchased by: (Name)

5d. Has Change of Ownership form been filed?

Yes No

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

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

Yes No

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

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(5)(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

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

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 No

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.

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

Private Patients (1080.0)

Publicly-Aided

-MA LV IV (Billed) (1100.2)

-MA Comm. for the Blind

LV IV (1104.1)

-VA & Other Public (1101.2)

Reserve for Bad Debts (1140.0) ( )

Total Accounts Receivables (1060.0)

Loans Receivable

Officers/Owners (1160.0)

Employees (1170.0)

Affiliates/Related Parties (1180.0)

Other Loans Receivable (1185.0)

Total Loans Receivable (1150.0)

Interest Receivable (1190.0)

Supply Inventory (1210.0)

Prepaid Expenses

Prepaid Interest (1270.0)

Prepaid Insurance (1280.0)

Prepaid Taxes (1290.0)

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)

\* See Instructions

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) Leasehold Improvements

Cost (1626.1)

Accum. Depr. (1627.2) ( )

Book Value (1625.0) Other Improvements

Cost (1631.1)

Accum. Depr. (1632.2) ( )

Book Value (1630.0) 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)

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)

Fully Depreciated Building1

Cost (1731.1)

Accum. Depr. (1732.1) ( )

Book Value (1733.1) Fully Depreciated Building Improvements1

Cost (1731.2)

Accum. Depr. (1732.2) ( )

Book Value (1733.2) Fully Amortized Leasehold Improvements1

Cost (1734.1)

Accum. Depr. (1734.2) ( )

Book Value (1734.0) Fully Depreciated Other Improvements1

Cost (1735.1)

Accum. Depr. (1735.2) ( )

Book Value (1735.0) Fully Depreciated HCF Cap.-Improvements1

Cost (1736.1)

Accum. Depr. (1736.2) ( )

Book Value (1736.0) Fully Depreciated Equipment1

Cost (1731.3)

Accum. Depr. (1732.3) ( )

Book Value (1733.3) Fully Depreciated HCF Cap.-Equipment1

Cost (1731.7)

Accum. Depr. (1732.7) ( )

Book Value (1733.7) Fully Depreciated Motor Vehicle1

Cost (1731.4)

Accum. Depr. (1732.4) ( )

Book Value (1733.4) Fully Depreciated Software/Ltd. Life Assets1

Cost (1731.5)

Accum. Depr. (1732.5) ( )

Book Value (1733.5) Fully Depreciated HCF Capitalization-Software/Ltd. Life Assets1

Cost (1731.6)

Accum. Depr. (1732.6) ( )

Book Value (1733.6)

Total Fixed Assets (1500.0)

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)

Other1 (1980.0)

Total Deferred Charges and Other Assets (1900.0)

TOTAL ASSETS (1000.0)

\* See Instructions

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

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LIABILITIES AND NET WORTH

Current Liabilities

Accounts Payable

|  |  |  |
| --- | --- | --- |
| Trade | (2020.0) |  |
| Accrued Expenses | (2030.0) |
| Due Comm. of Mass. | (2047.0) |
| Total Accounts Payable |  | (2010.0) |
| Patients Funds Due |  | (2050.0) |
| 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

Payments Due Within One Year

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)

Other Current Liabilities

Accr. St. & Fed. Taxes (2260.0)

Accrued Interest Payable (2270.0)

Other Current Liabilities (2290.0)

Total Other Current Liabilities (2250.0)

Total Current Liabilities (2005.0)

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)

Total Corporation (2610.0)

Total Net Worth (2500.0)

TOTAL LIABILITIES AND NET WORTH (2000.0)

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

GROSS INCOME

Private (3021.1)

|  |  |  |
| --- | --- | --- |
| DTA |  | (3022.5) |
| 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 Nonrecoverable1 (3120.0) | | |
| 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) |  |
| Fixed Costs Recoverable | (3196.0) |  |
| Total Miscellaneous and Recoverable Income |  | (3130.0) |
| TOTAL GROSS INCOME |  | (3000.0) |

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)

Officer Salaries\* (4125.1)

Other

Clerical Salaries1 (4140.1)

EDP/Payroll/Bkkpg Serv. (4150.3)

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

Management Consultants\* (4160.6)

Total Other (4130.1)

Total Administrative (4100.0)

General Supplies & Expenses

Office Supplies (4250.5)

Telephone

Phone (4261.5)

|  |  |  |
| --- | --- | --- |
| Directory Advertising | (4262.6) |  |
| Total Telephone |  | (4260.0) |
| Travel  Motor Vehicle Expense\* | (4275.5) |  |
| Conventions and Meetings | (4280.5) |  |
| Total Travel |  | (4270.5) |
| Advertising  Help Wanted | (4295.7) |  |
| Promotional | (4298.7) |  |
| Total Advertising |  | (4290.0) |

Licenses and Dues

Pt. Care Related Portion (4301.7)

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

Total Licenses and Dues (4300.0)

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 - Pensions1 | (4310.1) |  |
| Employee Benefits - Other | (4310.2) |
| Off.- Profit-Sharing & Bfts-Oth | (4339.2) |
| Total Employee Benefits |  | (4310.0) |
| Accounting  Appeal Service | (4350.3) |  |
| Other2 | (4360.3) |  |
| Total Accounting |  | (4340.0) |
| 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) |  |
| Payroll Taxes - Officers | (4411.2) |  |
| Total Payroll Taxes |  | (4400.0) |
| Insurance  Nonprofit DES Claims | (4428.7) |  |
| Malpractice and  General Liability\* | (4431.7) |  |
| Key Person Insurance | (4432.7) |  |
| Bldg, Impr. & Equip. | (4590.8) |  |
| Workers’ Compensation  Workers’ Comp - Other | (4424.1) |  |
| Workers’ Comp. - Officers | (4424.2) |  |

Group Life/Health

Group Life/Health - Other (4426.1)

Group Life/Health - Officers (4426.2)

Total Insurance (4420.0)

\* See Instructions

1 Provide 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.

|  |  |
| --- | --- |
| 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)

Total General Supplies and Expenses (4200.0)

Fixed Costs

Real Estate Taxes (4510.8)

Personal Property Taxes\* (4515.8)

Interest Long-Term2 (4520.8)

Rent - Real Property3

(HCF-2-RH Required) (4535.8)

Other (Explain below) (4538.8)

|  |  |
| --- | --- |
| Item | Expense |
| Equipment Rental |  |
| Other (Explain) |  |
| Other (Explain) |  |
| Total Other (4538.8) |  |

|  |  |  |
| --- | --- | --- |
| Depreciation - Building | (4550.8) |  |
| Depreciation - Bldg Improvement | (4565.8) |  |
| Depreciation - HCF Cap. Improvement | (4566.8) |  |
| Amortization - Leasehold Improvements | (4567.8) |  |
| Depreciation - Other Improvements | (4568.8) |  |
| Depreciation - Equipment | (4570.8) |  |
| 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) |

\* 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) |  |
| Purchased Service | (5110.3) |
| Supplies and Expenses | (5115.5) |
| Utilities | (5120.5) |
| Repairs | (5130.7) |
| Total Plant Operation, Maintenance & Security |  | (5100.0) |
| Dietary  Salaries | (5205.1) |  |
| Food | (5220.5) |  |
| Purchased Service | (5221.3) |  |
| Dietitian - Salary | (5231.1) |  |
| Dietitian - Purchased Service | (5233.3) |  |
| Supplies and Expenses | (5235.5) |  |
| Total Dietary |  | (5200.0) |

Laundry

Salaries (5310.1)

Purchased Service (5320.3)

Supplies and Expenses (5330.5)

Linen and Bedding (5340.5)

Total Laundry (5300.0)

Housekeeping

Salaries (5410.1)

Purchased Service (5415.3)

Supplies and Expenses (5420.5)

Total Housekeeping (5400.0)

Nursing

Registered Nurses

Salaries (6030.1)

RN Purchased Service (6035.3)

Licensed Practical Nurses

Salaries (6041.1)

LPN Purchased Service (6042.3)

Nurses' Aides

|  |  |  |
| --- | --- | --- |
| Salaries | (6051.1) |  |
| NA Purchased Service | (6052.3) |  |
| Total Nursing |  | (6000.0) |

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)

Resold to Private Patients (6523.5)

Total Medical Supplies and Drugs (6520.0)

Pharmacy Consultant (6530.0)

Social Service Worker (6540.0)

Total Medical Services (6500.0)

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) |  |  |
| Purchased Service | (7022.3) |  |
| Supplies and Expenses | (7023.5) |  |
| Transportation | (7024.8) |  |
| Total Recreational Therapy |  | (7020.0) |
| Total Restorative & Recreational Therapy |  |  | (7000.0) |
| Bad Accts.-Taxes-Refunds-Day Care  Bad Accounts |  | (8010.0) |  |
| Fines, Late Charges, and Penalties |  | (8015.0) |  |
| State & 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)

Less Non-Allowable Expenses

Schedule 13 Automatically Disallowed (9939.0)

Schedule 14 Self-Disallowed (9945.0)

Total Non-Allowable Expenses (4001.1)( )

|  |  |  |
| --- | --- | --- |
| Plus Additional Claimed Operating Expenses |  |  |
| Schedule 15 Claimed Fixed Costs | (9950.0) |
| 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) |

TOTAL ALLOWABLE OPERATING EXPENSES CLAIMED (4002.0)

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

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)

Total DTA (0210.0)

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 Public1

Resident Care (0270.5)

Total VA and Other Public (0270.0)

Private

Resident Care (0290.5)

Total Private (0290.0)

TOTAL RESIDENT DAYS: JANUARY 1, 2020 - MARCH 31, 2020 (0200.0)

APRIL 1, 2020 - JUNE 30, 2020

DTA (Massachusetts Only)

Resident Care (0310.5)

Total DTA (0310.0)

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 Public1

Resident Care (0370.5)

Total VA and Other Public (0370.0)

Private

Resident Care (0390.5)

Total Private (0390.0)

TOTAL RESIDENT DAYS: APRIL 1, 2020 - JUNE 30, 2020 (0300.0)

JULY 1, 2020 - SEPTEMBER 30, 2020

DTA (Massachusetts Only)

Resident Care (0410.5)

Total DTA (0410.0)

Massachusetts EAEDC

Resident Care (0412.5)

Massachusetts EAEDC (0412.0)

Non-Massachusetts DTA

Resident Care (0415.4)

Total Non-Massachusetts DTA (0415.0)

SCHEDULE 3 (continued): MA Commission for the Blind

Resident Care (0460.5)

Total MA Commission for the Blind (0460.0)

Veterans Administration and Other Public1

Resident Care (0470.5)

Total VA and Other Public (0470.0)

Private

Resident Care (0490.5)

Total Private (0490.0)

TOTAL RESIDENT DAYS: JULY 1, 2020 - SEPTEMBER 30, 2020 (0400.0)

OCTOBER 1, 2020 - DECEMBER 31, 2020

DTA (Massachusetts Only)

Resident Care (0510.5)

Total DTA (0510.0)

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 Public1

Resident Care (0570.5)

Total VA and Other Public (0570.0)

Private

Resident Care (0590.5)

Total Private (0590.0)

TOTAL RESIDENT DAYS: OCTOBER 1, 2020 - DECEMBER 31, 2020 (0500.0)

TOTAL RESIDENT DAYS - ENTIRE YEAR (0100.0)

Facility Name VPN or Provider ID

Balance Sheet Date (MO-DA-YR) 2020 HCF-4

|  |  |
| --- | --- |
| NUMBER OF ADMISSIONS DURING 2020 | (0140.0) |
| NUMBER OF DISCHARGES DURING 2020 | (0150.0) |
| NUMBER OF PUBLIC COMMUNITY SUPPORT ADMISSIONS - 2020 | (0170.0) |
| NUMBER OF TOTAL COMMUNITY SUPPORT ADMISSIONS - 2020 | (0175.0) |
| 2020 PUBLIC COMMUNITY SUPPORT RESIDENT DAYS | (0180.0) |
| 2020 PRIVATE COMMUNITY SUPPORT RESIDENT DAYS | (0182.0) |
| TOTAL COMMUNITY SUPPORT RESIDENT DAYS - 2020  . | (0185.0) |

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Facility Name VPN or Provider ID Balance Sheet Date (MO-DA-YR) 2020 HCF-4

SCHEDULE 5: ANALYSIS OF MORTGAGES AND NOTES PAYABLE

1. Mortgages and Notes Supporting Fixed Assets 1

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Lender  Name | Rel. Party Y/N | Date Mort. Acquired Mo-Da-Yr | Due Date  Mo-Da-Yr | No. of Months Amort. | Monthly  Payments | Original Mortgage Amount | Mort. Acq. Costs | Amort. of Mort. Acq Costs | Bal.  1/1/2020 | Principal  Payment | Bal.  12/31/2020 | Rate  % | Interest  Expense | Period  Expense\* |
| 1st Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2nd Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3rd Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4th Mortgage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chattel Note |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chattel Note |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Capital Lease |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals | XXXXX | XXX | XXXXX | XXXXX | XXXX | XXXXX | XXXXX |  |  | XXXX | XXXXX |  | XX |  |  |

2. Working Capital Debt 1

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

(a) (b) (c)

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

Total Working Capital Interest (4430.0)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 a new line separately.

2 The sum of the working capital interest expense.

\* See Instructions

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

Total Income Per Report (Account #3000.0) $

Total Operating Expenses (Account #4000.0) $

HCF-4 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.

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

1. Balance 12/31/2019 1 1

2. Other:

Prior Period

Adjustments: 2 xxxxxxxxxxxx xxxxxxxxxxxx

xxxxxxxxxxxx 2

3. Sale of Stock

xxxxxxxxxxxx xxxxxxxxxxxxx xxxxxxxxxxxx

4. Additional Paid-

In Capital xxxxxxxxxxxx

xxxxxxxxxxxxx xxxxxxxxxxxxx

5. HCF-4 Net Income

(Loss) Sch. 7 xxxxxxxxxxxx xxxxxxxxxxxxx

xxxxxxxxxxxxx

6. Dividends Paid xxxxxxxxxxxx xxxxxxxxxxxxx ( ) xxxxxxxxxxxxx ( )

7. Treasury Stock

Purchased/Sold xxxxxxxxxxxx xxxxxxxxxxxxx xxxxxxxxxxxxx

8. Balance 12/31/2020 3

3

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

1 This amount should agree with acct. #2500.0, Total Net Worth, page 12, on 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, on 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.

Acct # Amount Account Name

3150.0

3194.0

3196.0

4125.1

4160.3

4160.6

4262.6

4298.7

4302.3

4339.2

4350.3

4380.3

4385.7

4390.7

4411.2

4415.0

4424.2

4426.2

4430.0

4432.7

4435.0

4510.8

4515.8

4520.8

4535.8

4538.8

4550.8

4565.8

4566.8

4567.8

4568.8

4570.8

4576.8

4585.8

4586.8

4590.8

6520.5

6523.5

7012.1

7012.2

7014.3

7024.8

8010.0

8015.0

8025.5

8027.7

8030.0

8040.0

8065.0

(9939.0)

Vending Machines Income Recoverable Operating Costs Recoverable Fixed Costs

Officers Salaries & Directors' Fees

Management Fees Management Consultants Telephone Directory Advertising Advertising - Promotional

Licenses & Dues: Promotion, Goodwill & Legislative Portion

Officer - Profit-Sharing & Benefits-Other

Accounting - Appeal

Legal Appeal

Division of Administrative Law (DALA) - Filing Fees

Other Legal

Payroll Taxes - Officer

Interest on Late Payments, Penalties

Workers’ Compensation - Officer Group Life/Health - Officer Working Capital Interest

Keyman Insurance

Pre-opening Expenses

Real Estate Taxes Personal Property Taxes Interest - Long Term

Rent - Real Property Affiliate

Other Rent

Building - Depreciation

Building Improvement - Depreciation

HCF Capitalization - Improvement - Depreciation

Leasehold Improvement - Depreciation

Other Improvements – Depreciation

Equipment - Depreciation

HCF Capitalization - Equipment – Depreciation

Software/Limited Life Assets - Depreciation

HCF Capitalization - Software/Limited Life - Depreciation

Insurance - Building, Improvements & Equipment

Medical Supplies & Drugs - Legend Drugs

Resold to Private Patients

Restorative Therapy - Direct Salaries Restorative Therapy - Direct Benefits Restorative Therapy - Direct Consultants

Recreation Therapy - Transportation

Bad Accounts - Taxes - Refunds - Day Care

Bad Accounts - Fines - Late Charges - Penalties Massachusetts and Federal Income Taxes Massachusetts Excise Tax - Total

Refunds and Allowances

Adult Day Care Costs

Other Non-Nursing Facility Costs

TOTAL AUTOMATIC ADJUSTMENTS (Enter this amount on 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.)

Acct # Amount Account Name

4110.1

Responsible Person’s Salary

4140.1

Clerical Salaries

4150.3

EDP/Payroll/Bookkeeping Services

4250.5

Office Supplies

4261.5

Telephone

4275.5

Motor Vehicle Expense

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

Payroll Taxes - Other

4424.1

Workers’ Compensation - Other

4426.1

Group Life/Health - Other

4428.7

NonProfit DES Claims

4431.7

Malpractice/General Liability Insurance

4443.0

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

Acct # Amount Account Name

5220.5

Dietary - Food

5221.3

Dietary Purchased Service

5231.1

Dietician Salary

5233.3

Dietician Purchased Service

5235.5

Dietary - Supplies & Expenses

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

Recreation Therapy - Salaries

7022.3

Recreation Therapy - Purchased Service

7023.5

Recreation Therapy - Supplies & Expenses

(9945.0)

TOTAL SELF DISALLOWED

Facility Name VPN or Provider ID Balance Sheet Date (MO-DA-YR) 2020 HCF-4

SCHEDULE 15: DETAIL OF CLAIMED FIXED COSTS

The Center’s automatic adjustment process will disallow all fixed costs such as deprecation, 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.

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Allowable Basis or  Cost of Beg. Yr.1 | Claimed  Additions | Claimed  Deletions2 | Allowable Basis or  Cost End. of Yr | Rate% | Depreciation HCF-4 | From HCF-2-RH (If Applicable) |
| Land HCF-4 |  |  | ( ) |  | XXX | XXXXX | XXXXX |
| Land HCF-2-RH |  |  | ( ) |  | XXX | XXXXX | XXXXX |
| Building HCF-4 |  |  | ( ) |  | 2.5 |  | XXXXX |
| Building HCF-2-RH |  |  | ( ) |  | 2.5 | XXXXX |  |
| Improvements HCF-4 |  |  | ( ) |  | 5.0 |  | XXXXX |
| Improvements HCF-2-RH |  |  | ( ) |  | 5.0 | XXXXX |  |
| HCF Cap. Improv. HCF-4 |  |  | ( ) |  | 5.0 |  | XXXXX |
| HCF Cap. Improv. HCF-2-RH |  |  | ( ) |  | 5.0 | XXXXX |  |
| Equipment HCF-4 |  |  | ( ) |  | 10.0 |  | XXXXX |
| Equipment HCF-2-RH |  |  | ( ) |  | 10.0 | XXXXX |  |
| HCF Cap. Equip. HCF-4 |  |  | ( ) |  | 10.0 |  | XXXXX |
| HCF Cap. Equip. HCF-2-RH |  |  | ( ) |  | 10.0 | XXXXX |  |
| Software/Ltd. Life \* HCF-4 |  |  | ( ) |  | 33.3 |  | XXXXX |
| Software/Ltd. Life\* HCF-2-RH |  |  | ( ) |  | 33.3 | XXXXX |  |
| HCF Cap. Software/Ltd. Life Assets\* HCF-4 |  |  | ( ) |  | 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-4 Fixed Cost Recoverable Income |  |  |  |  |  | ( ) | ( ) |
| SUBTOTALS | XXXXX | XXXXX | XXXXX | XXXXX | XXX | (A) | (B) |
| TOTAL FIXED COSTS CLAIMED HCF-4 & HCF-2-RH (Post to Page 19) (A) + (B) | | | | | | | (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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| TOTAL | | | (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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| SUBTOTAL (Part 1) | |  |  | |

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) (4360.3)

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SCHEDULE 29: DETAIL OF EMPLOYEE WAGES AND BENEFITS

PART 1

\*See Instructions

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (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 |
| Staff  Development | (7110.2) |  | (7210.2) |  | (7310.2) |  | (4306.1) |  | (7410.2) |  | (7510.2) |  | (7610.2) |  |
| Maintenance  Staff | (7111.2) |  | (7211.2) |  | (7311.2) |  | (5105.1) |  | (7411.2) |  | (7511.2) |  | (7611.2) |  |
| Dietary Staff | (7112.2) |  | (7212.2) |  | (7312.2) |  | (5205.1) |  | (7412.2) |  | (7512.2) |  | (7612.2) |  |
| Dietician | (7113.2) |  | (7213.2) |  | (7313.2) |  | (5231.1) |  | (7413.2) |  | (7513.2) |  | (7613.2) |  |
| Laundry Staff | (7114.2) |  | (7214.2) |  | (7314.2) |  | (5310.1) |  | (7414.2) |  | (7514.2) |  | (7614.2) |  |
| Housekeeping  Staff | (7115.2) |  | (7215.2) |  | (7315.2) |  | (5410.1) |  | (7415.2) |  | (7515.2) |  | (7615.2) |  |
| 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  Services 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) |  | (7223.2) |  | (7323.2) |  | (7021.1) |  | (7423.2) |  | (7523.2) |  | (7623.2) |  |

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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) |  | (7224.2) |  | (7324.2) |  | (4110.1) |  | (7424.2) |  | (7524.2) |  | (7624.2) |  |
| Officer | (7125.2) |  | (7225.2) |  | (7325.2) |  | (4125.1) |  | (4426.2) |  | (7525.2) |  | (7625.2) |  |
| Clerical Staff | (7126.2) |  | (7226.2) |  | (7326.2) |  | (4140.1) |  | (7426.2) |  | (7526.2) |  | (7626.2) |  |
| RNs | (7129.2) |  | (7229.2) |  | (7329.2) |  | (6030.1) |  | (7429.2) |  | (7529.2) |  | (7629.2) |  |
| LPNs | (7130.2) |  | (7230.2) |  | (7330.2) |  | (6041.1) |  | (7430.2) |  | (7530.2) |  | (7630.2) |  |
| Nurses Aides | (7131.2) |  | (7231.2) |  | (7331.2) |  | (6051.1) |  | (7431.2) |  | (7531.2) |  | (7631.2) |  |

\*See Instructions

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