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

2020 HCF-4
RESIDENT CARE FACILITY REPORT

Batch # _____

1a. VPN _____

1b. Provider ID / MMIS #_____

2. Balance Sheet Date _____
(MO-DA-YR)

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
2. MA Corp - Chapter 156B with a 501 c.3 tax exemption
3. MA Corp - Chapter 180
4. Partnership
5. Sole Proprietorship
6. Governmental Entities
7. Other For-Profit
8. Other Non-Profit
9. Non MA Corp

7. Other Business Activities (Enter Y = Yes or N = No) _____
Child Day Care _____ Assisted Living _____
Adult Day Care _____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_____ 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)_____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.

Facility Name _____ VPN or Provider ID_____

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

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

_____ _____ 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 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

Facility Name _____ VPN or Provider ID_____

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

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:_____

Facility Name ____________________________ VPN or Provider ID________________

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

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___________________________

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	$	$	$	$	$

[1] Annual Draw or Earnings Distribution

Facility Name _____ VPN or Provider ID_____

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

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)

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?

Yes _____ No _____

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

Date From	Date To
_____	_____
_____	_____

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 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 Capitalization-Software/Ltd. Life Assets[1]

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) _____
Other[1]		(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.

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) _____**

Facility Name _____ VPN or Provider ID_____

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

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 Nonrecoverable[1]	(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 Salaries[1]	(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 - Pensions[1]	(4310.1)_____	
Employee Benefits - Other	(4310.2)_____	
Off.- Profit-Sharing & Bfts-Oth	(4339.2)_____	
Total Employee Benefits		(4310.0)_____
Accounting		
Appeal Service	(4350.3)_____	
Other[2]	(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-Term[2] (4520.8)_____

Rent - Real Property[3]
(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 Public[1]

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 Public[1]

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)_____**

[1] Identify Other Public Payers in detail on the Footnotes and Explanation section of this report as explained in Instructions.

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 Public[1]

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 Public[1]

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)_____**

[1] Identify Other Public Payers in detail on the Footnotes and Explanation section of this report as explained in Instructions.

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)_____**

.

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		
									(a)					(b)	(c)

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

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 Expense[2]
1									
2									
3									

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

Facility Name _____ VPN or Provider ID_____

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

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.

Facility Name _____ VPN or Provider ID_____

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

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]	_____	_____	_____	_____	_____ [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]	_____ (2620.0)	_____ (2630.0)	_____ (2650.0)	_____ (2640.0)	_____ [3] (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.

Facility Name _____ VPN or Provider ID_____

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

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	_____	Vending Machines Income
3194.0	_____	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	_____	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	_____	Division 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	_____	Building Improvement - Depreciation
4566.8	_____	HCF Capitalization - Improvement - Depreciation
4567.8	_____	Leasehold Improvement - Depreciation
4568.8	_____	Other Improvements – Depreciation
4570.8	_____	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	_____	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)	_____	**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

	Allowable Basis or Cost of 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			(_____)		**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]

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.

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)	

SCHEDULE 29: DETAIL OF EMPLOYEE WAGES AND BENEFITS

PART 1

(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)	

*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)		(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