# Rest Home Cost Report User Guide

**The HCF-4 serves the dual purpose of being a report to the Center that accurately reflects the complete financial condition of the facility, and at the same time, a claim for reimbursement. To accomplish the latter, columns numbered 2 and 3, labeled "Self-Disallowed Expenses" and "Automatically Disallowed Expenses" on the Statement of Profit and Loss have been provided to report non-allowable expenses and additional costs allocated to the facility by the management and/or realty companies. Additionally, column 2, "Self-Disallowed Expenses", is to be used for reporting specific costs that are NOT "ordinary and necessary" from a generally-accepted accounting or IRS standpoint, and which are not directly related to the care of publicly-aided residents; thus not reimbursable under current regulations. It is expected that the preparers and signatories of this cost report have a strong understanding of the regulations that govern cost reporting and reimbursement (101 CMR 204.00).**

| Cell Key | |
|---|---|
| Blue | Input by Data Submitter |
| Orange | Computation |
| Yellow | Derived from another Tab |
| Dotted Blue | From Cell on this Tab |
| Red | Non-Allowable Expense |
| Red Border Blue | Accepts Negative values |

## Tips For Completing the Cost Report

Cost Report Due Date: **5/1/2024**

Use whole dollar amounts.

For accounts or fields with no amounts or entry, leave blank.

For assistance with completing this form, email the LTCF Help Desk at: Costreports.LTCF@Chiamass.gov

## Cost Report Instructions

Detailed instructions for each line in the cost report is located at :

Information for Data Submitters: Resident Care Facility Cost Reports

* Preparer is to refer to the instruction guide for properly completing this line.

** Preparer is required to provide details in the Footnotes schedule of this cost report.

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# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : GENERAL INFORMATION

**Please check one:**

| | | |
|---|---|---|
| ☐ | **New Facility Requesting a Rate** | **Refer to 101 CMR 204.00 for what type of cost data must be submitted.** |
| ☐ | **Private Facility Requesting a Public Rate** | |
| ☑ | **Annual Report** | |
| ☐ | **Report of Major Addition or Substantial Capital Expenditure** | |

### Facility Information

| Table 1 | | 1 |
|---|---|---|
| Line # | **Description** | |
| 1.1 | VPN | 5508444 |
| 1.2 | Provider ID/MMIS ID | 110063114/A |
| 1.3 | Balance Sheet Date (MM/DD/YYYY) | 12/31/2023 |
| 1.4 | Name of Facility | ELLEN RICE REST HOME |
| 1.5 | Street Address | 38 WARNER STREET |
| 1.6 | City | SPRINGFIELD |
| 1.7 | Zip | 01103 |
| 1.8 | Telephone | 413-733-7162 |
| 1.9 | Federal Employer Identification Number | 04-3040702 |
| 1.10 | Responsible Person's Name | MICHAEL JOSEPH |
| 1.11 | Responsible Person's Email | rocket8266@gmail.com |
| 1.12 | Responsible Person's Affiliation (Select from Dropdown Menu) | PRESIDENT |
| 1.13 | List Name of Person to Receive Rate Notifications | MICHAEL JOSEPH |
| 1.14 | List Email of Person to Receive Rate Notifications | rocket8266@gmail.com |
| 1.15 | Status (Select Profit/Non-Profit from Dropdown Menu) | Profit |
| 1.16 | Legal Status (Select from Dropdown Menu) | 1. MA Corp-Chapter 156B |
| 1.17 | Does this facility have other business activities? If Yes, Explain in Table 1A. | No |
| 1.18 | Enter the number of Level IV licensed geriatric beds. | 12 |
| 1.19 | Enter the facility's constructed bed capacity. | 12 |
| 1.20 | Has there been a change in licensed beds during the year? If yes, complete Bed License Information Table 1B in the adjacent table. | No |
| 1.21 | Date of purchase by current owner (MM/DD/YYYY) | 09/23/1998 |
| 1.22 | Has the facility had a change in long-term financing during this cost report year? | No |
| 1.23 | Is the facility managed by a management company? | No |
| 1.24 | If line 1.23 is Yes, list the COMB# of the management company as reported on the management company cost report. | |
| 1.25 | If line 1.23 is Yes, list the name of the management company as reported on the management company cost report. | |
| 1.26 | Are you completing the HCF-2 RH (Realty Company Report) Tab in this Excel Workbook? | No |
| 1.27 | List realty company name(s) as reported on each realty company cost report. | N/A - NONE |
| 1.28 | Does the Balance Sheet schedule include any capitalized leases reported as assets? If yes, report the lease payments as a liability and include the lease on the Mortgages & Notes schedule. | No |
| 1.29 | Does the Profit Loss schedule include any expenses that have not been paid and reported as accrued liabilities, such as pension costs or self-insured workers' compensation? If yes, the unpaid or unfunded portions must be reported in column 2 of the Profit Loss schedule as self-disallowed expenses. | No |
| 1.30 | Does the Profit Loss schedule include any expenses for services of non-paid workers (volunteers) as provided in 101 CMR 204.07(6)? If yes, provide details of amounts and account numbers in the Footnotes schedule. | No |
| 1.31 | Did you report any employee's salary in more than one expense account? If yes, explain methodology of cost-splitting the salary in the Footnotes schedule. | No |
| 1.32 | Did you report any accrued expenses incurred in periods other than the current cost report period? If yes, you must report details of accrued expenses not related to the current cost report period in the Footnotes schedule. | No |

### Other Business Activities

| Table 1A | 1 | 2 | |
|---|---|---|---|
| Line # | **Other Business Activity** | **Select Yes/No from Dropdown Menu** | |
| 1A.1 | Child Day Care | | |
| 1A.2 | Adult Day Care | | |
| 1A.3 | Assisted Living | | |
| 1A.4 | Other: | | **Explain:** |

### Bed License Information

| Table 1B | 1 | 2 | 3 |
|---|---|---|---|
| Line # | **Date From** | **Date To** | **# of Beds** |
| 1B.1 | 01/01/2023 | 12/31/2023 | 12 |
| 1B.2 | | | |
| 1B.3 | | | |

## Contact Information

| Table 2 | | 1 |
|---|---|---|
| Line # | **Description** | |
| 2.1 | Contact Person Name | MICHAEL JOSEPH |
| 2.2 | Residential Care Facility or Firm Name | ELLEN RICE REST HOME |
| 2.3 | Title | PRESIDENT |
| 2.4 | Street Address | 38 WARNER STREET |
| 2.5 | City | SPRINGFIELD |
| 2.6 | State | MA |
| 2.7 | Zip Code | 01103 |
| 2.8 | Phone Number | 413-733-7162 |
| 2.9 | Email Address | rocket8266@gmail.com |

## Preparer Information

***Please use this section to provide contact information for a "Preparer," who is the authorizing person of this report, and is not the "Owner." If you are the sole authorized individual completing this report, please check the box below in Line 3.1.***

| Table 3 | | 1 |
|---|---|---|
| Line # | **Description** | |
| 3.1 | **I am the sole individual completing this cost report as an Owner, Partner, or Officer, and do not have a Preparer formally attesting to this information.** | ☐ |
| 3.2 | Preparer Name | PETER B PLUMB, CPA |
| 3.3 | Preparer's Affiliation | ACCOUNTANT |
| 3.4 | Nursing Facility or Firm Name | |
| 3.5 | Title | |
| 3.6 | Street Address | 83 CHURCH ST |
| 3.7 | City | WHITINSVILLE |
| 3.8 | State | MA |
| 3.9 | Zip Code | 01588 |
| 3.10 | Phone Number | 508-234-8311 |
| 3.11 | Email Address | peter@1040.org |
| 3.12 | Type of Accounting Service Performed | COMPILATION |

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : DISCLOSURES

**IMPORTANT:** This schedule is an integral part of the HCF-4 cost report. This schedule must be completed in its entirety. When completing this schedule the following definitions of direct and indirect beneficial owner apply: 1) A ***direct owner*** is defined as 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. 2) An **indirect beneficial owner** is defined as 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. This schedule MUST be completed in entirety.

### Direct and Indirect Owners

**List all direct and indirect owners with an interest of 5% or more in this facility. If the facility is owned by a corporation, chain, or trust, list the name of the corporation, chain, or beneficial owner under "Owner Name".**

| Table 1 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Line # | Owner Name (Last, First) | Address | Percent Ownership | Select Ownership Type | Select Direct or Indirect? |
| 1.1 | ELLEN RUCE REST HOME INC | 38 WARNER ST SPRINGFIELD MA | 100.0% | Corporation | Direct |
| 1.2 | JOSEPH, MICHAEL | 185 WHITAKER ST WESTFIELD MA | 100.0% | Person | Direct |
| 1.3 | | | | | |
| 1.4 | | | | | |
| 1.5 | | | | | |
| 1.6 | | | | | |

### Other Owned Facilities

**List the name(s) of any other nursing and/or residential care facilities in which the owners listed in Table 1 own, directly or indirectly, an interest of 5% or more.**

| Table 2 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Line # | Nursing and/or Rest Home | VPN | Name of Owner | Company Address | % Ownership |
| 2.1 | | | 0 | | |
| 2.2 | | | 0 | | |
| 2.3 | | | 0 | | |
| 2.4 | | | 0 | | |
| 2.5 | | | | | |

### Indebtedness

**List any indebtedness (mortgages, deeds, trust instruments, notes, or other financial information) of (1) the facility to the direct or indirect owners listed in Table 1 or (2) that the direct or indirect owners listed in Table 1 owe to the facility.**

| Table 3 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Line # | Select type of debt | Select Payable From | Original Debt Amount | Date Issued | Balance 12/31 | Select Payable To | List Owners Name |
| 3.1 | Note | ELLEN RICE REST HOME | VARIOUS | VARIOUS | - | M. JOSEPH | M. JOSEPH |
| 3.2 | | | | | | | |
| 3.3 | | | | | | | |
| 3.4 | | | | | | | |
| 3.5 | | | | | | | |

### Related Party Transactions

**Indicate any entity, person, or related party as defined in 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.)**

| Table 4 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Line # | Entity/Person | Goods/Services | Billing/Compensation | Mark up | Cost | Account Posted | Name of Owner | % Ownership |
| 4.1 | | | 0 | | - | | | |
| 4.2 | | | 0 | | - | | | |
| 4.3 | | | 0 | | - | | | |
| 4.4 | | | 0 | | - | | | |
| 4.5 | | | 0 | | - | | | |
| 4.6 | | | | | - | | | |

### Sole Proprietor, Partnership, or Corporate Information

**This schedule is used to report the names of the legal owners of the business and to disclose the salary and other compensation paid to owners as well as what accounts were charged. Sole proprietors should report the same amount as reported in the draw account and under no circumstances should any amount be claimed for personal services in an account other than draw. If additional space is needed, use the Footnotes and Explanations Tab.**

| Table 5 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Select Owner, Partner, Officer | Owner Name | Owner Title | % Time Devoted | Salary | Employee Benefits | Payroll Taxes | Workers' Comp. | Gr. Life/Health Ins. | Draw | Other | Total |
| 5.1 | | | | | | | | | | | | - |
| 5.2 | | | | | | | | | | | | - |
| 5.3 | | | | | | | | | | | | - |
| 5.4 | | | | | | | | | | | | - |
| 5.5 | | | | | | | | | | | | - |
| 5.6 | | | | | | | | | | | | - |
| 5.7 | | | | | | | | | | | | - |
| 5.8 | | | | | | | | | | | | - |

### Five Highest Paid Salaries

**List the names, salaries, and benefits of the five employees who have the highest compensation being claimed on this report.**

| Table 6 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Name | Title | % Time Devoted - Administrative | % Time Devoted- Plant Operation, Maintenance, and Security | % Time Devoted - Medical Services | % Time Devoted - Other | Total Time (Must equal 100%) | Salary | Employee Benefits | Payroll Taxes | Workers' Comp. | Gr. Life/Health Ins. | Draw | Other | Total |
| 6.1 | MICHAEL JOSEPH | ADMINISTRATOR | 100.00% | | | | **100.00%** | 134,950 | | 10,834 | 32 | | | | **145,816** |
| 6.2 | TAMARA JOSEPH | RN | | | 100.00% | | **100.00%** | 101,060 | | 8,287 | 901 | | | | **110,248** |
| 6.3 | JENNIFER MORALES | AIDE | | | 100.00% | | **100.00%** | 34,793 | | 2,853 | 499 | | | | **38,145** |
| 6.4 | REVELIANA GREENE | DIETARY | | | | 100.00% | **100.00%** | 37,468 | | 3,072 | 1,185 | | | | **41,725** |
| 6.5 | THEODORE JOSEPH | AIDE | | | 100.00% | | **100.00%** | 10,300 | | 1,030 | 73 | | | | **11,403** |

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : BALANCE SHEET

| *Current Assets* | | | |
|---|---|---|---|
| **Table 1** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| | | ***Cash and Cash Equivalents*** | |
| 1.1 | 1020.0 | Cash - Checking Account | 79,367 |
| 1.2 | 1030.0 | Cash - On Hand | 0 |
| 1.3 | 1040.0 | Temporary Investments | 0 |
| 1.4 | 1050.0 | Other Cash | 0 |
| **1.100** | **1010.0** | **Total Cash and Cash Equivalents** | **79,367** |
| | | ***Accounts Receivable*** | |
| 1.5 | 1080.0 | Private Patients | - |
| 1.6 | 1100.2 | Publicly-Aided - MA LV IV (Billed) | 22,843 |
| 1.7 | 1104.1 | Publicly-Aided - MA Commission for the Blind LV IV | - |
| 1.8 | 1101.2 | Publicly-Aided - VA and Other Public | - |
| 1.9 | 1140.0 | Reserve for Bad Debts | - |
| **1.200** | **1060.0** | **Total Accounts Receivable** | **22,843** |
| | | ***Loans Receivable*** | |
| 1.10 | 1160.0 | Loans Receivable from Officers/Owners | - |
| 1.11 | 1170.0 | Loans Receivable from Employees | - |
| 1.12 | 1180.0 | Loans Receivable from Affiliates/Related Parties | - |
| 1.13 | 1185.0 | Other Loans Receivable | - |
| **1.300** | **1150.0** | **Total Loans Receivable** | **-** |
| 1.14 | 1190.0 | Interest Receivable | - |
| 1.15 | 1210.0 | Supply Inventory | - |
| | | ***Prepaid Expenses*** | |
| 1.16 | 1270.0 | Prepaid Interest | - |
| 1.17 | 1280.0 | Prepaid Insurance | - |
| 1.18 | 1290.0 | Prepaid Taxes | - |
| 1.19 | 1295.0 | Capitalized Pre-Opening Costs * | - |
| 1.20 | 1300.0 | Other Prepaid Expenses * | - |
| **1.400** | **1260.0** | **Subtotal Prepaid Expenses** | **-** |
| 1.21 | 1310.0 | Other Current Assets | - |
| **100** | **1005.0** | **Total Current Assets** | **102,210** |

| *Fixed Assets* | | | | | |
|---|---|---|---|---|---|
| ***Do not report fully depreciated assets on this table.*** | | | | | |
| **Table 2** | | | 1 | 2 | 3 |
| Line # | Account # | **Description** | **Cost** | **Accumulated Depreciation** | **Net Book Value** |
| 2.1 | 1510.0 | Land | 5,000 | | **5,000** |
| 2.2 | 1520.0 | Building | 45,000 | (27,240.00) | **17,760** |
| 2.3 | 1610.0 | Building Improvements | - | - | **0** |
| 2.4 | 1625.0 | Leasehold Improvements | - | - | **0** |
| 2.5 | 1630.0 | Other Improvements | - | - | **0** |
| 2.6 | 1650.0 | Equipment | 37,710 | (36,750.00) | **960** |
| 2.7 | 1700.0 | Motor Vehicles | - | - | **0** |
| 2.8 | 1710.0 | Software/Limited Life Assets | - | - | **0** |
| **200** | **1500.0** | **Total Non-Current Fixed Assets** | | | **23,720** |

| *Deferred Charges and Other Assets* | | | |
|---|---|---|---|
| **Table 3** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| 3.1 | 1910.0 | Organization Expense | - |
| 3.2 | 1940.0 | Purchased Goodwill | - |
| 3.3 | 1950.0 | Leasehold Deposits | - |
| 3.4 | 1960.0 | Utility Deposits | - |
| 3.5 | 1970.0 | Cash Surrender Value of Officer Life Insur. | - |
| 3.6 | 1975.1 | Mortgage Acquisition Costs * | - |
| 3.7 | 1975.2 | Accumulated Amortization of Mortgage Acquisition Costs | - |
| 3.8 | 1975.0 | Unamortized Mortgage Acquisition Costs | - |
| 3.9 | 1979.0 | Construction in Progress * | - |
| 3.10 | 1980.0 | Other ** | - |
| **3.100** | **1900.0** | **Total Deferred Charges and Other Assets** | **-** |
| **300** | **1000.0** | **Total Assets** | **125,930** |

| *Current Liabilities* | | | |
|---|---|---|---|
| **Table 4** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| | | ***Accounts Payable*** | |
| 4.1 | 2020.0 | Trade Payables | 4,694 |
| 4.2 | 2030.0 | Accrued Expenses | 5,423 |
| 4.3 | 2047.0 | Due to Commonwealth of MA | - |
| **4.100** | **2010.0** | **Total Accounts Payable** | **10,117** |
| 4.4 | 2050.0 | Patient Funds Due | - |
| | | ***Notes and Loans Payable (See Mortgages & Notes Schedule)*** | |
| 4.5 | 2110.0 | Officer, Owner, or Related Parties | - |
| 4.6 | 2120.0 | Subsidiaries and Affiliates | - |
| 4.7 | 2130.0 | Banks | - |
| 4.8 | 2140.0 | Motor Vehicles | - |
| 4.9 | 2150.0 | Other Short-Term Financing | - |
| 4.10 | 2160.0 | Payment Due Within One Year on Long-Term Debt * | - |
| **4.200** | **2100.0** | **Total Notes and Loans Payable** | **-** |
| | | ***Accrued Salaries and Payroll Liabilities*** | |
| 4.11 | 2190.0 | Accrued Salaries | 7,646 |
| 4.12 | 2200.0 | Accrued Payroll Tax Withheld | - |
| 4.13 | 2210.0 | Accrued Employee Taxes Payable | - |
| 4.14 | 2220.0 | Other Payroll Liabilities | - |
| **4.300** | **2180.0** | **Total Accrued Salaries and Payroll Liabilities** | **7,646** |
| | | ***Other Current Liabilities*** | |
| 4.15 | 2260.0 | State and Federal Taxes Payable | - |
| 4.16 | 2270.0 | Accrued Interest Payable | - |
| 4.17 | 2290.0 | Other Current Liabilities | - |
| **4.400** | **2250.0** | **Total Other Current Liabilities** | **0** |
| **400** | **2005.0** | **Total Current Liabilities** | **17,763** |

| *Long-Term Liabilities* | | | |
|---|---|---|---|
| **Table 5** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| | | ***Long-Term Liabilities (See Mortgages & Notes Schedule)*** | |
| 5.1 | 2310.0 | Mortgages * | - |
| 5.2 | 2320.0 | Other Long Term Debt * | - |
| **5.100** | **2300.0** | **Total Long-Term Liabilities** | **0** |
| **500** | **N/A** | **Total Liabilities** | **17,763** |

| *Net Worth* | | | |
|---|---|---|---|
| **Table 6** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| | | ***Proprietorship or Partnership Capital*** | |
| 6.1 | 2520.0 | Capital | 0 |
| 6.2 | 2530.0 | Proprietor Drawings | 0 |
| 6.3 | 2540.0 | Partner Drawings | 0 |
| 6.4 | 2550.0 | Net Profit(Loss) - Current Year | 0 |
| **6.100** | **2510.0** | **Total Proprietorship or Partnership Capital** | **0** |
| 6.5 | 2620.0 | Capital Stock | 10,000 |
| 6.6 | 2630.0 | Additional Paid in Capital | 0 |
| 6.7 | 2640.0 | Treasury Stock | 0 |
| 6.8 | 2650.0 | Retained Earnings | 98,167 |
| **6.200** | **2610.0** | **Total Corporation Capital** | **108,167** |
| **600** | **2000.0** | **Total Liabilities and Net Worth** | **125,930** |

| *Balance Sheet Check* | | | |
|---|---|---|---|
| **Table 7** | | | 1 |
| Line # | Account # | **Description** | **Account Balance** |
| **7.1** | **1000.0** | **Total Assets** | 125,930 |
| **7.2** | **2000.0** | **Total Liabilities and Net Worth** | 125,930 |
| | | **Difference** | **Balance Sheet Check Passed** |

Footnote Legend

* Preparer is to refer to the instruction guide for properly completing this line. A link to the instructions is provided in the User Guide Tab.

** Preparer is required to provide details in the Footnotes schedule of this cost report.

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : Profit Loss Statement

**Gross Income**

| Table 1 | | | |
|---|---|---|---|
| Line # | Account # | Description | 1<br>Reported Amount |
| 1.1 | 3021.1 | Private | 0 |
| 1.2 | 3022.5 | DTA | 358,208 |
| 1.3 | 3022.6 | MA DTA Patient Resource Income | 91,543 |
| 1.4 | 3022.7 | Non-MA DTA | 0 |
| 1.5 | 3023.1 | MA Commission for the Blind | 0 |
| 1.6 | 3023.2 | VA and Other Public | 0 |
| 1.7 | 3025.3 | Adult Day Care Income | 0 |
| 1.8 | 3026.2 | Other Non-Nursing Income | 0 |
| 1.9 | | COVID-Related Supplemental Payments | 91,182 |
| ***Ancillary Services (Use Table 1A to Right to Itemize Expenses)*** | | | |
| 1.10 | 3031.1 | Private | 0 |
| 1.11 | 3032.5 | Medicaid (DMA) | 0 |
| 1.12 | 3032.7 | Non-MA Medicaid | 0 |
| 1.13 | 3033.1 | MA Commission for the Blind | 0 |
| 1.14 | 3033.2 | VA & Other Public | 0 |
| **1.100** | **3030.0** | **Total Ancillary Services** | **0** |
| ***Miscellaneous and Recoverable Income*** | | | |
| 1.15 | 3120.0 | Endowment & Other Nonrecoverable ** | 0 |
| 1.16 | 3140.0 | Laundry Recoverable Income | 0 |
| 1.17 | 3150.0 | Vending Machines Recoverable Income | 0 |
| 1.18 | 3160.0 | Bad Debt Recovery | 0 |
| 1.19 | 3170.0 | Prior Year Retroactive Adjustment | 0 |
| 1.20 | 3180.0 | Interest Income | 0 |
| 1.21 | 3194.0 | Operating Costs Recoverable | 0 |
| 1.22 | 3196.0 | Fixed Costs Recoverable | 0 |
| **1.200** | **3130.0** | **Total Miscellaneous and Recoverable Income** | **0** |
| **100** | **3000.0** | **Total Gross Income** | **540,933** |

**Table 1A : Detail of Ancillary Services Expenses**

***Report these amounts as non-allowable expenses on main schedule.***

| Line # | Account # | Expense Classification | Amount |
|---|---|---|---|
| 1A.1 | | | |
| 1A.2 | | | |
| 1A.3 | | | |
| 1A.4 | | | |
| 1A.5 | | | |
| **1A.100** | | **Total Ancillary Expenses** | **0** |

**Expenses**

| Table 2 | | | | | | |
|---|---|---|---|---|---|---|
| Line # | Account # | Description | 1<br>Reported Expenses | 2<br>Self Disallowed Expenses (9945.0) | 3<br>Automatically Disallowed Expenses (9939.0) | 4<br>Total Allowable Expenses |
| ***Administrative Expenses*** | | | | | | |
| 2.1 | 4110.1 | Administrative/Responsible Person Salaries | 134,950 | | | 134,950 |
| 2.2 | 4125.1 | Officer Salaries* | 0 | | 0 | 0 |
| ***Other Expenses*** | | | | | | |
| 2.3 | 4140.1 | Clerical Salaries (Use Table 2A to Right to Itemize Salaries) | 0 | | | 0 |
| 2.4 | 4150.3 | Electronic Data Processing, Payroll, and Bookkeeping Services | 8,048 | | | 8,048 |
| 2.5 | 4160.3 | Management Fees | 0 | | 0 | 0 |
| 2.6 | 4160.6 | Management Consultants* | 0 | | 0 | 0 |
| **2.100** | **4130.1** | **Total Other Expenses** | **8,048** | **0** | **0** | **8,048** |
| **2.200** | **4100.0** | **Total Administrative Expenses** | **142,998** | **0** | **0** | **142,998** |
| ***General Supplies & Expenses*** | | | | | | |
| 2.7 | 4250.5 | Office Supplies | 5,628 | | | 5,628 |
| | | | | | | |
| 2.8 | 4261.5 | Phone | 4,285 | | | 4,285 |
| 2.90 | 4262.6 | Directory Advertising | 0 | | 0 | 0 |
| **2.300** | **4260.0** | **Total Telephone Expenses** | **4,285** | **0** | **0** | **4,285** |
| ***Travel Expenses*** | | | | | | |
| 2.10 | 4275.5 | Motor Vehicle Expense* | 6,841 | | | 6,841 |
| 2.11 | 4280.5 | Conventions and Meetings | 0 | | | 0 |
| **2.400** | **4270.5** | **Total Travel Expenses** | **6,841** | **0** | | **6,841** |
| ***Advertising Expenses*** | | | | | | |
| 2.12 | 4295.7 | Help Wanted | 0 | | | 0 |
| 2.13 | 4298.7 | Promotional | 0 | | 0 | 0 |
| **2.500** | **4290.0** | **Total Advertising Expenses** | **0** | **0** | **0** | **0** |
| ***Licenses and Dues Expenses*** | | | | | | |
| 2.14 | 4301.7 | Licenses and Dues: Patient Care Related Portion | 3,835 | | | 3,835 |
| 2.15 | 4302.3 | Licenses and Dues: Not Related to Patient Care | 0 | | 0 | 0 |
| **2.600** | **4300.0** | **Total Licenses and Dues Expenses** | **3,835** | **0** | **0** | **3,835** |
| ***Education and Training Expenses*** | | | | | | |
| 2.16 | 4306.1 | Staff Development: Coordinator Salary | 0 | | | 0 |
| 2.17 | 4306.2 | Administration Training | 0 | | | 0 |
| 2.18 | 4306.3 | Other Required Education | 0 | | | 0 |
| 2.19 | 4306.4 | Job Related Education | 0 | | | 0 |
| **2.700** | **4305.0** | **Total Education and Training Expenses** | **0** | **0** | | **0** |
| ***Employee Benefits*** | | | | | | |
| 2.20 | 4310.1 | Employee Benefits - Pensions ** | 0 | | | 0 |
| 2.21 | 4310.2 | Employee Benefits - Other | 0 | | | 0 |
| 2.22 | 4339.2 | Officer Profit Sharing and Other Benefits | 0 | | 0 | 0 |
| **2.800** | **4310.0** | **Total Employee Benefits** | **0** | **0** | **0** | **0** |
| ***Accounting Expenses*** | | | | | | |
| 2.23 | 4350.3 | Accounting: Appeal Services | 0 | | 0 | 0 |
| 2.24 | 4360.3 | Accounting: Other (Use Table 2B to Right to Itemize Expenses) | 9,510 | | | 9,510 |
| **2.900** | **4340.0** | **Total Accounting Expenses** | **9,510** | **0** | **0** | **9,510** |
| ***Legal Expenses*** | | | | | | |
| 2.25 | 4380.3 | Legal: Appeal Service | 0 | | 0 | 0 |
| 2.26 | 4385.7 | Legal: Division of Administrative Law Appeals - Filing Fees | 0 | | 0 | 0 |
| 2.27 | 4390.7 | Other Legal | 0 | | 0 | 0 |
| **2.1000** | **4370.0** | **Total Legal Expenses** | **0** | | **0** | **0** |
| ***Payroll Taxes*** | | | | | | |
| 2.28 | 4411.1 | Payroll Taxes - Other | 24,701 | | | 24,701 |
| 2.29 | 4411.2 | Payroll Taxes - Officers | 0 | | 0 | 0 |
| **2.1100** | **4400.0** | **Total Payroll Taxes** | **24,701** | **0** | **0** | **24,701** |
| ***Insurance Expense*** | | | | | | |
| 2.30 | 4428.7 | Insurance: Department of Unemployment Assistance Claims (DUA) - A&G Portion | 0 | | | 0 |
| 2.31 | 4431.7 | Insurance: Malpractice and General Liability * | 5,467 | | | 5,467 |
| 2.32 | 4432.7 | Key Person Insurance | 0 | | 0 | 0 |
| 2.33 | 4590.8 | Insurance: Building Improvements and Equipment | 3,845 | | (3,845) | 0 |
| 2.34 | 4424.1 | Workers' Comp - Other | 2,692 | | | 2,692 |
| 2.35 | 4424.2 | Workers' Comp - Officers | 0 | | 0 | 0 |
| 2.36 | 4426.1 | Group Life/Health - Other | 3,486 | | | 3,486 |
| 2.37 | 4426.2 | Group Life/Health - Officers | 0 | | 0 | 0 |
| **2.1200** | **4420.0** | **Total Insurance Expenses** | **15,490** | **0** | **(3,845)** | **11,645** |
| 2.38 | 4415.0 | Interest on Late Payments, Penalties | 0 | | 0 | 0 |
| 2.39 | 4430.0 | Interest on Working Capital | - | | 0 | 0 |
| 2.40 | 4435.0 | Pre-Opening Expenses | 0 | | 0 | 0 |
| 2.41 | 4443.00 | Other Operating Expenses (Use Table 2C to Right to Itemize Expenses) | 1,575 | | | 1,575 |
| **2.1300** | **4200.0** | **Total General Supplies and Expenses** | **71,865** | **0** | **(3,845)** | **68,020** |

**Table 2A : Detail of Clerical Salaries**

| Line # | Employee Name | Job Title | Brief Job Description | Gross Salary |
|---|---|---|---|---|
| 2A.1 | | | | 0 |
| 2A.2 | | | | 0 |
| 2A.3 | | | | 0 |
| 2A.4 | | | | 0 |
| 2A.5 | | | | |
| 2A.6 | | | | |
| 2A.7 | | | | |
| 2A.8 | | | | |
| 2A.9 | | | | |
| 2A.10 | | | | |
| 2A.11 | | | | |
| 2A.12 | | | | |
| 2A.13 | | | | |
| 2A.14 | | | | |
| 2A.15 | | | | |
| 2A.16 | | | | |
| **2A.100** | | **Total Clerical Salaries** | | **0** |

**Note: Use Column 2 of the main expense schedule to disallow any disallowed salaries for clerical staff that worked on other business activities.**

**Table 2B : Detail of Other Accounting Expenses**

**Part 1: Purchased Service Accounting Expenses**

| Line # | Vendor Name | Date Occurred (MM/DD/YYYY) | Amount | Select Code | Brief Description of Service |
|---|---|---|---|---|---|
| 2B.1 | PETER B. PLUMB, CPA | 12/31/2023 | 6,310 | A | PREPARATION OF HCF REPORTS |
| 2B.2 | PETER B. PLUMB, CPA | 12/31/2023 | 800 | D | PERSONAL TAX PREPARATION |
| 2B.3 | PETER B. PLUMB, CPA | 12/31/2023 | 2,400 | C | CORPORATE TAX PREPARATION |
| 2B.4 | | | | | |
| 2B.5 | | | | | |
| **2B.100** | | **Sub-Total** | **9,510** | | |

**Part II: Employee's Responsibilities Only**

| Line # | Employee Name | Job Title | Salary | Select Code | Description of Responsibilities | % of time |
|---|---|---|---|---|---|---|
| 2B.6 | | | | | | |
| 2B.7 | | | | | | |
| 2B.8 | | | | | | |
| 2B.9 | | | | | | |
| **2B.200** | | **Sub-Total** | **0** | | | |
| **2B.300** | | **Total Other Accounting** | **9,510** | | | |

**Accounting Expense Codes**

| | | |
|---|---|---|
| **A. HCF-4 Cost Report Prep** | **D. Personal Tax Prep** | **G. SEC Filings** |
| **B. Medicare Cost Report Prep** | **E. Management Advisory Services** | **H. Other Allowable Accounting (Explain)** |
| **C. Corporate Tax Prep** | **F. Certified Financial Statement Audit** | **I. Other Non-Allowable Accounting (Explain)** |
| | **Explain if using Code H and/or I :** | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2.42 | 4510.8 | Real Estate Taxes | 7,457 | | (7,457) | 0 |
| 2.43 | 4515.8 | Personal Property Taxes* | 0 | | 0 | 0 |
| 2.44 | 4520.8 | Interest Long-Term (See Mortgages & Notes Schedule) | - | | 0 | 0 |
| 2.45 | 4535.8 | Rent - Real Property | | | 0 | 0 |
| 2.46 | 4538.8 | Other Rent (Use Table 2D to Right to Itemize Expenses) | 0 | | 0 | 0 |
| 2.47 | 4550.8 | Depreciation - Building | 1,135 | | (1,135) | 0 |
| 2.48 | 4565.8 | Depreciation - Building Improvements | 0 | | 0 | 0 |
| 2.49 | 4567.8 | Depreciation - Leasehold Improvements | 0 | | 0 | 0 |
| 2.50 | 4568.8 | Depreciation - Other Improvements | 0 | | 0 | 0 |
| 2.51 | 4570.8 | Depreciation - Equipment | 240 | | (240) | 0 |
| 2.52 | 4585.8 | Depreciation - Software/Limited Life Assets | 0 | | 0 | 0 |
| **2.1400** | **4540.0** | **Total Fixed Costs** | **8,832** | | **(8,832)** | **0** |
| ***Plant Operation, Maintenance & Security*** | | | | | | |
| 2.53 | 5105.1 | Plant Operations, Maintenance & Security - Salaries | 0 | | | 0 |
| 2.54 | 5110.3 | Plant Operations, Maintenance & Security - Purchased Service | 4,440 | | | 4,440 |
| 2.55 | 5115.5 | Plant Operations, Maintenance & Security - Supplies and Expenses | 20,467 | | | 20,467 |
| 2.56 | 5120.5 | Plant Operations, Maintenance & Security - Utilities | 16,293 | | | 16,293 |
| 2.57 | 5130.7 | Plant Operations, Maintenance & Security - Repairs | 13,745 | | | 13,745 |
| **2.1500** | **5100.0** | **Total Plant Operation, Maintenance & Security** | **54,945** | **0** | | **54,945** |
| ***Dietary*** | | | | | | |
| 2.58 | 5205.1 | Dietary - Salaries | 37,468 | | | 37,468 |
| 2.59 | 5220.5 | Dietary - Food | 59,795 | | | 59,795 |
| 2.60 | 5221.3 | Dietary - Purchased Service | 0 | | | 0 |
| 2.61 | 5231.1 | Dietician - Salary | 0 | | | 0 |
| 2.62 | 5233.3 | Dietician - Purchased Service | 268 | | | 268 |
| 2.63 | 5235.5 | Dietary - Supplies and Expenses | 0 | | | 0 |
| **2.1600** | **5200.0** | **Total Dietary** | **97,531** | **0** | | **97,531** |
| ***Laundry*** | | | | | | |
| 2.64 | 5310.1 | Laundry - Salaries | 0 | | | 0 |
| 2.65 | 5320.3 | Laundry - Purchased Service | 2,408 | | | 2,408 |
| 2.66 | 5330.5 | Laundry - Supplies and Expenses | 0 | | | 0 |
| 2.67 | 5340.5 | Laundry - Linen and Bedding | 750 | | | 750 |
| **2.1700** | **5300.0** | **Total Laundry** | **3,158** | **0** | | **3,158** |
| ***Housekeeping*** | | | | | | |
| 2.68 | 5410.1 | Housekeeping - Salaries | 0 | | | 0 |
| 2.69 | 5415.3 | Housekeeping - Purchased Service | 0 | | | 0 |
| 2.70 | 5420.5 | Housekeeping - Supplies and Expenses | 2,550 | | | 2,550 |
| **2.1800** | **5400.0** | **Total Housekeeping** | **2,550** | **0** | | **2,550** |
| ***Nursing*** | | | | | | |
| ***Registered Nurses*** | | | | | | |
| 2.71 | 6030.1 | RN Salaries | 101,060 | | | 101,060 |
| 2.72 | 6035.3 | RN Purchased Service | 0 | | | 0 |
| | | | | | | |
| 2.73 | 6041.1 | LPN Salaries | 0 | | | 0 |
| 2.74 | 6042.3 | LPN Purchased Service | 0 | | | 0 |
| ***Nurses Aides*** | | | | | | |
| 2.75 | 6051.1 | Nurses Aides Salaries | 35,360 | | | 35,360 |
| 2.76 | 6052.3 | Nurses Aides Purchased Service | 0 | | | 0 |
| **2.1900** | **6000.0** | **Total Nursing** | **136,420** | **0** | | **136,420** |
| **Medical Services** | | | | | | |
| 2.77 | 6504.1 | Quality Assurance Professional | 0 | | | 0 |
| 2.78 | 6507.1 | Community Support Coordinator | 0 | | | 0 |
| ***Physicians' Services*** | | | | | | |
| 2.79 | 6514.3 | Employee Physicals | 0 | | | 0 |
| 2.80 | 6515.3 | Other Medical Services Expenses (Use Table 2E to Right to Itemize Expenses) | 0 | | | 0 |
| **2.2000** | **6510.0** | **Total Physicians' Services** | **0** | **0** | | **0** |
| **Medical Supplies & Drugs** | | | | | | |
| 2.81 | 6520.5 | Legend Drugs | 0 | | 0 | 0 |
| 2.82 | 6522.5 | House Supplies Not Resold | 1,721 | | | 1,721 |
| 2.83 | 6523.5 | Resold to Private Patients | 0 | | 0 | 0 |
| **2.2100** | **6520.0** | **Total Medical Supplies and Drugs** | **1,721** | **0** | **0** | **1,721** |
| 2.84 | 6530.0 | Pharmacy Consultant | | | | 0 |
| 2.85 | 6540.0 | Social Service Worker (Including Behavioral Health) | | | | 0 |
| **2.2200** | **6500.0** | **Total Medical Services** | **1,721** | **0** | **0** | **1,721** |
| ***Restorative & Recreational Therapy*** | | | | | | |
| ***Restorative Therapy*** | | | | | | |
| 2.86 | 7011.1 | Indirect Restorative Therapy Salaries | 0 | | | 0 |
| 2.87 | 7012.1 | Direct Restorative Therapy Salaries | 0 | | 0 | 0 |
| 2.88 | 7012.2 | Direct Restorative Therapy Benefits | 0 | | 0 | 0 |
| 2.89 | 7013.3 | Indirect Restorative Therapy Consultants | 0 | | | 0 |
| 2.90 | 7014.3 | Direct Restorative Therapy Consultants | 0 | | 0 | 0 |
| **2.2300** | **7010.0** | **Total Restorative Therapy** | **0** | **0** | **0** | **0** |
| ***Recreational Therapy*** | | | | | | |
| 2.91 | 7021.1 | Recreational Therapy - Salaries | 0 | | | 0 |
| 2.92 | 7022.3 | Recreational Therapy - Purchased Service | 0 | | | 0 |
| 2.93 | 7023.5 | Recreational Therapy - Supplies and Expenses | 3,077 | | | 3,077 |
| 2.94 | 7024.8 | Recreational Therapy - Transportation | 0 | | 0 | 0 |
| **2.2400** | **7020.0** | **Total Recreational Therapy** | **3,077** | **0** | **0** | **3,077** |
| **2.2500** | **7000.0** | **Total Restorative & Recreational Therapy** | **3,077** | **0** | **0** | **3,077** |
| ***Bad Accts.-Taxes-Refunds-Day Care*** | | | | | | |
| 2.95 | 8010.0 | Bad Accounts - Refunds, Taxes, Day Care | 0 | | 0 | 0 |
| 2.96 | 8015.0 | Fines, Late Charges, and Penalties | 0 | | 0 | 0 |
| 2.97 | 8025.5 | State & Federal Income Taxes | 0 | | 0 | 0 |
| 2.98 | 8027.7 | Massachusetts Excise Tax | 456 | | (456) | 0 |
| 2.99 | 8030.0 | Refunds and Allowances | 0 | | 0 | 0 |
| 2.101 | 8040.0 | Adult Day Care Costs* | 0 | | 0 | 0 |
| 2.102 | 8065.0 | Other Non-Nursing Costs* | 0 | | 0 | 0 |
| **2.2600** | **8000.0** | **Total Bad Accts.-Taxes-Refunds-Day Care** | **456** | | **(456)** | **0** |
| **200** | **4000.0** | **Total Expenses** | **523,553** | **0** | **(13,133)** | **510,420** |
| | | | **A/C # 4000.0** | **A/C #9545.0** | **A/C # 9939.0** | |

**Table 2C: Detail of Other Operating Expenses**

| Line # | Description | Amount |
|---|---|---|
| 2C.1 | CONTRIBUTIONS | 1,575 |
| 2C.3 | 0 | 0 |
| 2C.4 | 0 | 0 |
| **2C.100** | **Total** | **1,575** |

**Table 2D: Detail of Other Rent Expenses**

| Line # | Description | Amount |
|---|---|---|
| 2D.1 | Equipment Rental | |
| 2D.2 | | |
| 2D.3 | | |
| 2D.4 | | |
| **2D.100** | **Total** | **0** |

**Table 2E: Detail of Other Medical Services Expenses**

| Line # | Description | Amount |
|---|---|---|
| 2E.1 | | 0 |
| 2E.2 | | 0 |
| 2E.3 | | 0 |
| 2E.4 | | 0 |
| **2E.100** | **Total** | **0** |

| Reconciliation of Reported Operating Expenses to Allowable Operating Expenses | | | |
|---|---|---|---|
| Table 3 | | | 1 |
| Line # | Account # | Description | Amount |
| 3.1 | 4000.0 | Total Reported Operating Expenses | 523,553 |
| 3.2 | 9945.0 | Less: Self-Disallowed Expenses | 0 |
| 3.3 | 9939.0 | Less: Automatically Disallowed Expenses | (13,133) |
| **3.100** | **4001.1** | **Total Non-Allowable Expenses** | **(13,133)** |
| 3.4 | 9960.3 | Allocated Administrative and General from Management Company (HCF-3) | |
| 3.5 | 9502.2 | Other Operating Expense Add-Back from Realty Company (HCF-2 RH) | |
| 3.6 | 9963.3 | Allocated Other Operating Expense Add-Back from Management Company | |
| 3.7 | 9961.3 | Allocated Fixed Asset Expenses from Management Company (HCF-3) | |
| 3.8 | 9500.0 | Claimed Fixed Asset Expenses from Claimed Fixed Assets Schedule | 12,565 |
| 3.9 | 9302.6 | Allocated Direct Variable (Dietican, Indirect Therapy & QA) Management Company Add-Back Expenses | |
| 3.10 | 9302.8 | Allocated Direct Director of Nurses Management Company Add-Back Expenses | |
| **3.200** | **4001.2** | **Total Allowable Add-Back Expenses** | **12,565** |
| 3.41 | NA | Less: Recoverable Income (offsetting operating expenses) | 0 |
| **300** | **4002.0** | **Total Allowable Operating Expenses Claimed** | **522,985** |

| Reconciliation of Cost Report Net Income to Financial Statement (Book) Net Income | | | |
|---|---|---|---|
| Table 4 | | | 1 |
| Line # | Account # | Description | Amount |
| ***Cost Report Net Income*** | | | |
| 4.1 | 3000.0 | Total Cost Report Income | 540,933 |
| 4.2 | 4000.0 | Total Cost Report Expenses | 523,553 |
| **4.100** | | **Net Income (Loss) Cost Report** | **17,380** |
| ***Financial Statement Net Income*** | | | |
| 4.3 | | Financial Statement Reported Income | |
| 4.4 | | Financial Statement Reported Expenses | |
| **4.200** | | **Net Income (Loss) Financial Statement** | **0** |
| ***Variance*** | | | |
| 4.5 | | Variance Between Cost Report and Financial Statements: Income | **540933** |
| 4.6 | | Variance Between Cost Report and Financial Statements: Expenses | **523553** |
| 4.7 | | Variance Between Cost Report and Financial Statements: Net Income | **17380** |
| ***Reconciling Items*** | | | |
| 4.8 | | Reconciling Item: Explain | |
| 4.9 | | Reconciling Item: Explain | |
| 4.10 | | Reconciling Item: Explain | |
| 4.11 | | Reconciling Item: Explain | |
| 4.12 | | Reconciling Item: Explain | |
| **4.300** | | **Total Reconciling Items** | **0** |
| ***Reconciliation*** | | | |
| **400** | | **Difference between Total Reconciling Items and Variance Between Cost Report and Financial Statements: Net Income ***** | **17,380** |

Footnote Legend

* Preparer is to refer to the instruction guide for properly completing this line. A link to the instructions is provided in the User Guide Tab.

** Preparer is required to provide details in the Footnotes schedule of this cost report.

*** This should be zero. The variance in the net income should be accounted for by the reconciling items.

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : RESIDENT DAYS

| Resident Days January 1 - March 31 | | | |
|---|---|---|---|
| **Table 1** | Account # | | 1 |
| **Line #** | | **Payer Description** | **Reported Days** |
| 1.1 | 0210.5 & 0210.0 | DTA Days | 728 |
| 1.2 | 0212.5 & 0212.0 | Massachusetts EAEDC | 282 |
| 1.3 | 0215.4 & 0215.0 | Non-Massachusetts DTA | |
| 1.4 | 0260.5 & 0260.0 | MA Commission for the Blind | |
| 1.5 | 0270.5 & 0270.0 | Veterans Administration and Other Public ** | |
| 1.6 | 0290.5 & 0290.0 | Private | |
| **100** | **0200.0** | **Total Resident Days January 1 - March 31** | **1,010** |

| Resident Days April 1 - June 30 | | | |
|---|---|---|---|
| **Table 2** | Account # | | 1 |
| **Line #** | | **Payer Description** | **Reported Days** |
| 2.1 | 0310.5 & 0310.0 | DTA Days | 728 |
| 2.2 | 0312.5 & 0312.0 | Massachusetts EAEDC | 294 |
| 2.3 | 0315.4 & 0315.0 | Non-Massachusetts DTA | |
| 2.4 | 0360.5 & 0360.0 | MA Commission for the Blind | |
| 2.5 | 0370.5 & 0370.0 | Veterans Administration and Other Public ** | |
| 2.6 | 0390.5 & 0390.0 | Private | |
| **200** | **0300.0** | **Total Resident Days April 1 - June 30** | **1,022** |

| Resident Days July 1 - September 30 | | | |
|---|---|---|---|
| **Table 3** | Account # | | 1 |
| **Line #** | | **Payer Description** | **Reported Days** |
| 3.1 | 0410.5 & 0410.0 | DTA Days | 736 |
| 3.2 | 0412.5 & 0412.0 | Massachusetts EAEDC | 297 |
| 3.3 | 0415.4 & 0415.0 | Non-Massachusetts DTA | |
| 3.4 | 0460.5 & 0460.0 | MA Commission for the Blind | |
| 3.5 | 0470.5 & 0470.0 | Veterans Administration and Other Public ** | |
| 3.6 | 0490.5 & 0490.0 | Private | |
| **300** | **0400.0** | **Total Resident Days July 1 - September 30** | **1,033** |

| Resident Days October 1 - December 31 | | | |
|---|---|---|---|
| **Table 4** | Account # | | 1 |
| **Line #** | | **Payer Description** | **Reported Days** |
| 4.1 | 0510.5 & 0510.0 | DTA Days | 736 |
| 4.2 | 0512.5 & 0512.0 | Massachusetts EAEDC | 297 |
| 4.3 | 0515.4 & 0515.0 | Non-Massachusetts DTA | |
| 4.4 | 0560.5 & 0560.0 | MA Commission for the Blind | |
| 4.5 | 0570.5 & 0570.0 | Veterans Administration and Other Public ** | |
| 4.6 | 0590.5 & 0590.0 | Private | |
| **400** | **0500.0** | **Total Resident Days October 1 - December 31** | **1,033** |

| Annual Resident Days January 1-December 31 | | | |
|---|---|---|---|
| **Table 5** | Account # | | 1 |
| **Line #** | | **Payer Description** | **Total Reported Days** |
| 5.1 | 0610.5 & 0610.0 | DTA Days | **2,928** |
| 5.2 | 0612.5 & 0612.0 | Massachusetts EAEDC | **1,170** |
| 5.3 | 0615.4 & 0615.0 | Non-Massachusetts DTA | **0** |
| 5.4 | 0660.5 & 0660.0 | MA Commission for the Blind | **0** |
| 5.5 | 0670.5 & 0670.0 | Veterans Administration and Other Public ** | **0** |
| 5.6 | 0690.5 & 0690.0 | Private | **0** |
| **500** | **0600.0** | **Total Annual Resident Days** | **4,098** |

| Additional Patient Day Information | | | |
|---|---|---|---|
| **Table 6** | | 1 | |
| **Line #** | | **Description** | **Reported Admission/Community Support Days** |
| 6.1 | 0140.0 | Number of Admissions | 3 |
| 6.2 | 0150.0 | Number of Discharges | 3 |
| 6.3 | 0170.0 | Number of Public Community Support Admissions | |
| 6.4 | 0175.0 | Number of Total Community Support Admissions | |
| 6.5 | 0180.0 | Public Community Support Resident Days | |
| 6.6 | 0182.0 | Private Community Support Resident Days | |
| **600** | **0185.0** | **Total Community Support Resident Days** | **0** |

Footnote Legend

** Preparer is required to provide details in the Footnotes schedule of this cost report.

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : CLAIMED FIXED ASSETS

### Claimed Fixed Asset Expenses

**Note: This table does not include all fixed assets for the facility; only those that can be claimed as residential care facility fixed assets. Allowable basis is the portion of fixed assets used for the care of publicly-aided residents. Claimed deletions include retired, sold, written-off, damaged, and fully depreciated assets. If the facility runs other non-nursing or residential care programs, such as an adult day care program, the related fixed asset expenses must be NOT be reported on this schedule and the allocation methodology for allocating fixed asset expenses must be reported in the Footnotes and Explanations schedule.**

| Table 1 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Description | Allowable Cost Basis Beginning Balance | Claimed Additions | Claimed Deletions | Allowable Cost Basis Ending Balance | Depreciation % | Depreciation HCF-4 | Non-Allowable Depreciation Expense | Add-Backs from HCF-2 RH if applicable | Claimed Net Depreciation Expense |
| 1.1 | Land HCF-4 | 2,000 | | 0 | 2,000 | | | | | |
| 1.2 | Land HCF-2 | | | 0 | 0 | | | | | |
| 1.3 | Building HCF-4 | 22,699 | | 0 | 22,699 | 2.50% | 567 | | | 567 |
| 1.4 | Building HCF-2 | | | 0 | 0 | 2.50% | | | - | 0 |
| 1.5 | Improvements HCF-4 | | | 0 | 0 | 5.00% | 0 | | | 0 |
| 1.6 | Improvements HCF-2 | | | 0 | 0 | 5.00% | | | - | 0 |
| 1.7 | Equipment HCF-4 | 36,417 | 1,200 | 0 | 37,617 | 10.00% | 240 | | | 240 |
| 1.8 | Equipment HCF-2 | | | 0 | 0 | 10.00% | | | - | 0 |
| 1.9 | Software/Limited Life Assets HCF-4 | | | 0 | 0 | 33.33% | 0 | | | 0 |
| 1.10 | Software/Limited Life Assets HCF-2 | | | 0 | 0 | 33.33% | | | - | 0 |
| **100** | **Total Claimed Fixed Asset Depreciation Expense** | **61,116** | **1,200** | **0** | **62,316** | | **807** | **0** | **0** | **807** |

### Other Claimed Fixed Asset Expenses

**Report other claimed fixed asset expenses other than depreciation below. If the facility runs other non-nursing or residential care programs, such as an adult day care program, the related fixed asset expenses must NOT be reported on this schedule and the allocation methodology for allocating fixed asset expenses must be reported in the Footnotes and Explanations schedule.**

| Table 2 | | 1 | 2 | 3 |
|---|---|---|---|---|
| Line # | Description | Claimed Fixed Asset Expenses - Rest Home (HCF-4) | Claimed Fixed Asset Expenses - Realty Company (HCF-2 RH) | Total Other Claimed Fixed Asset Expenses |
| 2.1 | Long-Term Interest Claimed * | 0 | - | 0 |
| 2.2 | MA Corporate Excise Tax - Non-Income Portion | 456 | - | 456 |
| 2.3 | Building Insurance | 3,845 | - | 3,845 |
| 2.4 | Real Estate Taxes | 7,457 | - | 7,457 |
| 2.5 | Personal Property Taxes | 0 | - | 0 |
| 2.6 | Other Claimed Fixed Assets** | | - | 0 |
| **200** | **Total Claimed Fixed Asset Other Expenses** | **11,758** | **0** | **11,758** |

## Total Claimed Fixed Asset Expenses

| Table 3 | | 1 | |
|---|---|---|---|
| Line # | Description | Total | |
| 300 | Total Fixed Assets Expenses Claimed | 12,565 | A/C 9500.0 |

## General Fixed Cost Information

| Table 4 | | 1 |
|---|---|---|
| Line # | Description | |
| 4.1 | Is this a new facility? | No |
| 4.2 | What is the year the facility was built? (YYYY) | 19XX |
| 4.3 | Was there a change of ownership of this facility during the reporting period? | No |
| 4.4 | Was there a change of ownership of company that owns the real assets of the facility (realty company) during the reporting period? | No |

## Changes in Facility or Realty Company Ownership

| Table 5 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Line # | Select Type of Ownership Change | Transaction Date | Purchased From | Purchased By | Sale Price |
| 5.1 | Sale of Residential Care Facility Between Current Owners (e.g. related parties) | | | | |
| 5.2 | Sale of Residential Care Facility to Unrelated Third Party | | | | |
| 5.3 | Sale of Realty Company | | | | |

## New Facilities, Major Additions, and Substantial Capital Expenditures

| Table 6 | | 1 | 2 | |
|---|---|---|---|---|
| Line # | Description | Response | Reference | |
| 6.1 | Is this a new facility? If so, does this cost report project the reasonably anticipated costs and anticipated resident days for a twelve-month period? | No | Refer to regulation 101 CMR 204.08(1)(a) | |
| 6.2 | Did your facility have any major additions that became operational during the year? If so, does this cost report project the reasonably anticipated costs and anticipated resident days for a twelve-month period? | No | Refer to regulation 101 CMR 204.08(1)(a) | |
| 6.3 | If yes to the above question(s), provide the date the facility or major additions became operational. (MM/DD/YYYY) | | Refer to regulation 101 CMR 204.08(1)(a) | |
| 6.4 | Did your facility file a petition with CHIA for an administrative adjustment for substantial capital expenditures during the year? | No | Refer to regulation 101 CMR 204.08(2)(a) 1. | |
| 6.5 | If yes to question 6.4, provide the date of the petition. (MM/DD/YYYY) | | Refer to regulation 101 CMR 204.08(2)(a) 1. | |
| 6.6 | Were the substantial capital expenditures subject to a Determination of Need (DON) approval by the Department of Public Health (DPH)? If yes, complete DON Schedule below. | No | Refer to regulation 101 CMR 204.08(2)(a) 1. | |
| 6.7 | If yes to question 6.6, list expenditures. | Equipment | Improvements | Limited Life Assets |
| | | | | |

| Determination of Need (DON) Project Details | | | | |
|---|---|---|---|---|
| **Table 7** | | 1 | | |
| Line # | **Description** | **Response** | | |
| 7.1 | List the DON project number. | | | |
| 7.2 | Please briefly describe the DON project. | | | |
| 7.3 | What is the date of the original DON approval? (MM/DD/YYYY) | | | |
| 7.4 | What is the approved Maximum Capital Expenditure of the original DON? | | | |
| 7.5 | Has this facility received a letter from the DPH Office of Determination of Need approving any significant change in the capital project resulting in an increase in the Maximum Capital Expenditure? | | | |
| 7.6 | What is the date that assets were placed into service this period? (MM/DD/YYYY) | | | |
| 7.7 | List the net book value and category of fixed assets that were written off or retired during this reporting year as a result of the DON project. | **Equipment** | **Improvements** | **Limited Life Assets** |
| | | | | |

Footnote Legend

* Preparer is to refer to the instruction guide for properly completing this line. A link to the instructions is provided in the User Guide Tab.

** Preparer is required to provide details in the Footnotes schedule of this cost report.

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : MORTGAGES AND NOTES

**IMPORTANT NOTE: Report all mortgages and notes payable whether or not interest expense is incurred on this schedule. Each new note should be reported with all data fields completely filled in. New mortgages or enhancements of existing mortgages must be reported on a separate line. Total Mortgages and Notes as of December 31 and Total Expenses must match amounts reported on the Balance Sheet and the Profit or Loss schedules.**

### Mortgages and Notes Supporting Fixed Assets

| Table 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Select Type of Notes Payable | Lender Name | Related Party Yes/No Selection | Date Mortgage Acquired | Due Date | Number of Months Amortized | Monthly Payments | Original Loan Amount | Mortgage Acquisition Costs | Amortization of Mortgage Acquisition Costs | Beginning Loan Balance: Jan 1 | Beginning Balance - New Loans | Principal Payments | Pay Off Amount | Pay Off Date | Ending Loan Balance: Dec 31 | Interest Rate % | Interest Expense | Period Expenses | Total Fixed Interest (Amortization, Interest and Period Expenses) |
| 1.1 | | | | | | | | | | | - | - | - | - | | - | | | | - |
| 1.2 | | | | | | | | | | | - | - | - | - | | - | | | | - |
| 1.3 | | | | | | | | | | | - | - | - | - | | - | | | | - |
| 1.4 | | | | | | | | | | | - | - | - | - | | - | | | | - |
| 1.5 | | | | | | | | | | | | | | | | - | | | | - |
| 1.6 | | | | | | | | | | | | | | | | - | | | | - |
| 1.7 | | | | | | | | | | | | | | | | - | | | | - |
| 1.8 | | | | | | | | | | | | | | | | - | | | | - |
| **100** | **TOTALS** | | | | | | | | - | - | | | | | | - | | - | - | - |
| | | | | | | | | | | (A) | | | | | | | | (B) | (C) | (A) + (B) + (C) |
| | | | | | | | | | | | | | | | | | | | | **A/C # 4520.8** |

### Working Capital Debt

| Table 2 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| Line # | Lender Name | Related Party Yes/No Selection | Beginning Balance: Jan 1 | New Loan Amount | Start Date | Principal Payments | Ending Balance: Dec 31 | Interest Rate % | Interest Expense |
| 2.1 | MICHAEL JOSEPH | No | 27,849 | - | VARIOUS | (27,849) | - | | |
| 2.2 | | | - | - | | | - | | |
| 2.3 | | | - | - | | | - | | |
| 2.4 | | | | | | | - | | |
| 2.5 | | | | | | | - | | |
| 2.6 | | | | | | | - | | |
| **200** | **TOTALS** | | | | | | - | | - |
| | | | | | | | **A/C # 2100.0 less 2160.0** | | **A/C # 4430.0** |

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : WAGES AND BENEFITS

**Detail of Staff, Hours, Salary, and Benefits by Position**

| Table 1 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|---|
| Line # | Description | Number of FTE (Round to one decimal place) | Number of Staff (Round to one decimal place) | Total Hours (Round to one decimal place) | Total Salaries | Group Life/Health Benefits | Pensions | Other Benefits |
| 1.1 | Staff Development | #VALUE! | | | - | | | |
| | | 7110.2 | 7210.2 | 7310.2 | 4306.1 | 7410.2 | 7510.2 | 7610.2 |
| 1.2 | Maintenance Staff | #VALUE! | | | - | | | |
| | | 7111.2 | 7211.2 | 7311.2 | 5105.1 | 7411.2 | 7511.2 | 7611.2 |
| 1.3 | Dietary Staff | 00,001.1 | 1.0 | 2265.0 | 37,468 | | | |
| | | 7112.2 | 7212.2 | 7312.2 | 5205.1 | 7412.2 | 7512.2 | 7612.2 |
| 1.4 | Dietician | #VALUE! | | | - | | | |
| | | 7113.2 | 7213.2 | 7313.2 | 5231.1 | 7413.2 | 7513.2 | 7613.2 |
| 1.5 | Laundry Staff | #VALUE! | | | - | | | |
| | | 7114.2 | 7214.2 | 7314.2 | 5310.1 | 7414.2 | 7514.2 | 7614.2 |
| 1.6 | Housekeeping Staff | #VALUE! | | | - | | | |
| | | 7115.2 | 7215.2 | 7315.2 | 5410.1 | 7415.2 | 7515.2 | 7615.2 |
| 1.7 | Quality Assurance | #VALUE! | | | - | | | |
| | | 7116.2 | 7216.2 | 7316.2 | 6504.1 | 7416.2 | 7516.2 | 7616.2 |
| 1.8 | Community Support Coordinator | #VALUE! | | | - | | | |
| | | 7119.2 | 7219.2 | 7319.2 | 6507.1 | 7419.2 | 7519.2 | 7619.2 |
| 1.9 | Social Services Staff | #VALUE! | | | - | | | |
| | | 7120.2 | 7220.2 | 7320.2 | 6540.0 | 7420.2 | 7520.2 | 7620.2 |
| 1.10 | Restorative - Indirect Salaries | #VALUE! | | | - | | | |
| | | 7121.2 | 7221.2 | 7321.2 | 7011.1 | 7421.2 | 7521.2 | 7621.2 |
| 1.11 | Restorative - Direct Salaries | #VALUE! | | | - | | | |
| | | 7122.2 | 7222.2 | 7322.2 | 7012.1 | 7422.2 | 7522.2 | 7622.2 |
| 1.12 | Recreational Staff | #VALUE! | | | - | | | |
| | | 7123.2 | 7223.2 | 7323.2 | 7021.1 | 7423.2 | 7523.2 | 7623.2 |
| 1.13 | Administrator | 00,001.0 | 1.0 | 2080.0 | 134,950 | | | |
| | | 7124.2 | 7224.2 | 7324.2 | 4110.1 | 7424.2 | 7524.2 | 7624.2 |
| 1.14 | Officer | #VALUE! | | | - | | | - |
| | | 7125.2 | 7225.2 | 7325.2 | 4125.1 | 7425.2 | 7525.2 | 7625.2 |
| 1.15 | Clerical Staff | #VALUE! | | | - | | | |
| | | 7126.2 | 7226.2 | 7326.2 | 4140.1 | 7426.2 | 7526.2 | 7626.2 |
| 1.16 | RNs | 00,001.3 | 1.0 | 2778.0 | 101,060 | | | |
| | | 7129.2 | 7229.2 | 7329.2 | 6030.1 | 7429.2 | 7529.2 | 7629.2 |
| 1.17 | LPNs | #VALUE! | | | - | | | |
| | | 7130.2 | 7230.2 | 7330.2 | 6041.1 | 7430.2 | 7530.2 | 7630.2 |
| 1.18 | Nurses Aides | 00,001.1 | 2.0 | 2222.0 | 35,360 | 3,486 | | |
| | | 7131.2 | 7231.2 | 7331.2 | 6051.1 | 7431.2 | 7531.2 | 7631.2 |

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : FOOTNOTES AND EXPLANATIONS

| Table 1 | 1 | 2 | 3 |
|---|---|---|---|
| **Enter any footnotes, explanations or disagreement relating to this cost report in the space provided below by schedule. 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 discrepancies. For your convenience, all lines in the cost report marked with ** are listed below. If you reported values on any of cost report lines marked with an **, you must provide an explanation on this schedule.** | | | |
| **Cost Report** | **Schedule Name** | **Line #/ / Line Name** | **Explanation** |
| HCF-4 | Balance Sheet | Line # 3.10/ Other | |
| HCF-4 | Profit or Loss Schedule | Line # 1.15 /Endowment & Other Nonrecoverable Income | X 0 |
| HCF-4 | Profit or Loss Schedule | Line # 2.20 /Employee Benefits - Pensions | |
| HCF-4 | Profit or Loss Schedule | Lines # 1.5, 2.5, 3.5, 4.5/Veterans Administration and Other Public | |
| HCF-4 | Profit or Loss Schedule | Line # 2.6/ Other Claimed Fixed Assets | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #3650.0/Other Income | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #9321.1/Clerical | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #9323.7/Other Expenses | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #9399.6/Total Other Administrative, Variable & DON Costs | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #9379.0/Miscellaneous | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #9391.0/Other Property Costs | |
| HCF-3 RH | Part III - Management Company Financial Information | Acct. #1980.0/Other | |
| HCF-4 | General | Line #1.30/Report of unpaid workers expenses | |
| HCF-4 | General | Line #1.31/Cost-splitting methodology for employees whose salaries are reported in more than one account. | |
| HCF-4 | General | Line # 1.32/Details of accrued expenses not related to the current cost report period. | |
| HCF-4 | Profit or Loss Schedule | CELL F104 in Profit Loss is protected | cannot disallow charity donations made |

| | | | |
|---|---|---|---|
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# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : CERTIFICATIONS

| Certification by Preparer (Other than Owner, Partner, or Officer) | | | |
|---|---|---|---|
| **Table 1** | | 1 | |
| 1.1 | Firm Name / Realty Company | PETER B. PLUMB, CPA | |
| 1.2 | Preparer's Last Name | PLUMB | |
| 1.3 | Preparer's First Name | PETER | |
| 1.4 | Preparer's Middle Name | B. | |
| 1.5 | Title | CPA | |
| 1.6 | Street Address | 83 CHURCH ST | |
| 1.7 | City | WHITINSVILLE | |
| 1.8 | State | MA | |
| 1.9 | Zip Code | 01588 | |
| 1.10 | Phone Number | 508-234-8311 | |
| 1.11 | Email Address | peter@1040.org | |
| 1.12 | **By checking this box and completing line 1.13, Date of Authorization, I hereby certify that I am the Preparer of this report noted above and I attest, to the best of my knowledge and belief, that this cost report is a true, correct, and complete statement. This report is subject to audit and verification by the Center for Health Information and Analysis.** | | ☑ |
| 1.13 | Date of Authorization: | 5/1/2024 | |

| Certification by Owner, Partner, or Officer | | | |
|---|---|---|---|
| **Table 2** | | 1 | |
| 2.1 | Last Name | JOSEPH | |
| 2.2 | First Name | MICHAEL | |
| 2.3 | Middle Name | H. | |
| 2.4 | Title | PRESIDENT | |
| 2.5 | **By checking this box and completing line 2.6, Date of Authorization, I declare and affirm under the penalties of perjury that this cost report and supporting schedules have been examined by me and, to the best of my knowledge and belief, are a true and correct statement of total operating expenditures, balance sheet, earnings and expenses, and other required information. Further, I declare that the report and supplemental information were prepared from the books and records of the provider, unless otherwise noted, in accordance with applicable federal and state laws, regulations and instructions. I understand that any payment resulting from this report will be from state and federal funds and that any false statements or documents, or the concealment of a material fact, may be prosecuted under applicable federal and state laws. I also understand that this report and supporting schedules are subject to audit and verification by the Center for Health Information and Analysis or any other state or federal agency or their subcontractors. I will keep all records, books, and other information pertaining to this cost report for a period of five years. If there is an unresolved audit exception, I will keep these records until all issues are resolved.** |  |
| 2.6 | Date of Authorization | 5/1/2024 | |

# RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

## SCHEDULE : Condensed Realty Company Cost Report (HCF-2 RH)

The HCF-2 RH must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 6320.8 "Rent Expenses for Real Property". This schedule must be completed whenever rent is paid to an individual, partnership, realty trust or other entity whether affiliated or not with the residential care facility. The HCF-2 RH serves the dual purpose of being a report to the Center by the individual or business entity which owns the real property to accurately reflect the complete financial condition AND a claim for reimbursement.

## Part I: Facility Specific Realty Company Information and Disclosures

### Facility Information

| Table 1 | | |
|---|---|---|
| Line # | Description | 1 |
| 1.1 | Realty Company Name | N/A - NONE |
| 1.2 | FEIN | - |
| 1.3 | Realty Company CBCSO # | - |
| 1.4 | Balance Sheet Date | 12/31/2023 |
| 1.5 | Realty Company Address | 0 |
| 1.6 | City | 0 |
| 1.7 | Zip | 00000 |
| 1.8 | Telephone | |

**IMPORTANT:** Tables 2 through 6 are an integral part of the HCF-4 cost report. These tables must be completed in its entirety. When completing these tables the following definitions of direct and indirect beneficial owner apply: 1) A **direct owner** is defined as a person or entity having any rights or benefits of ownership and having ***an interest of record*** in ay partnership, joint venture, corporation or other entity; and 2) An **indirect beneficial owner** is defined as 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. These tables MUST be completed in entirety.

### Direct and Indirect Owners

List all direct and indirect owners with an interest of 5% or more in this realty company. If the realty company is owned by a corporation, chain, or trust, list the name of the corporation, chain, or beneficial owner under "Owner Name".

| Table 2 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Line # | Owner Name (Last, First) | Address | Percent Ownership | Select Ownership Type | Direct or Indirect? |
| 2.1 | ELLEN RUCK REVOCABLE TRUST | 28 MORGAN ST SPRINGFIELD MA | 100.0% | Corporation | Direct |
| 2.2 | JOSEPH L MICHAEL | 185 WHITMARSH ST WESTFIELD MA | 100.0% | Person | Direct |
| 2.3 | | | | | |
| 2.4 | | | | | |
| 2.5 | | | | | |
| 2.6 | | | | | |

### Other Owned Facilities

List the name(s) of any other nursing and/or residential care facilities in which the owners listed in Table 2 own, directly or indirectly, an interest of 5% or more.

| Table 3 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Line # | Nursing and/or Rest Home | MPN | Name of Owner | Company Address | % Ownership |
| 3.1 | | | 0 | | |
| 3.2 | | | 0 | | |
| 3.3 | | | 0 | | |
| 3.4 | | | 0 | | |
| 3.5 | | | | | |

### Indebtedness

List any indebtedness (mortgages, deeds, trust instruments, notes, or other financial information) of (1) the realty company to the direct or indirect owners listed in Table 2 or (2) the direct or indirect owners listed in Table 2 to the realty company.

| Table 4 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Line # | Select type of debt | Select Payable From | Original Debt Amount | Date Issued | Balance 12/31 | Select Payable To | List Owners Name |
| 4.1 | | | | | | | |
| 4.2 | | | | | | | |
| 4.3 | | | | | | | |
| 4.4 | | | | | | | |
| 4.5 | | | | | | | |

### Related Party Transactions

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

| Table 5 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Line # | Entity/Person | Goods/Services | Billing/Compensation | Mark up | Cost | Account Posted | Name of Owner | % Ownership |
| 5.1 | | | | | - | | | |
| 5.2 | | | | | - | | | |
| 5.3 | | | | | - | | | |
| 5.4 | | | | | - | | | |
| 5.5 | | | | | - | | | |
| 5.6 | | | | | - | | | |

### Proprietor, Partnership, or Corporate Information

This schedule is used to report the names of the legal owners of the business and to disclose the salary and other compensation paid to owners as well as what accounts were charged. Sole proprietors should report the same amount as reported in the draw account and under no circumstances should any amount be claimed for personal services in an account other than draw. If additional space is needed, use the Footnotes and Explanations Tab.

| Table 6 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Select Owner, Partner, Officer | Owner Name | Owner Title | % Time Devoted | Salary | Employee Benefits | Payroll Taxes | Workers' Comp. | Gr. Life/Health Ins. | Draw | Other | Total |
| 6.1 | | SEE HCF-2 | | | | | | | | | | - |
| 6.2 | | | | | | | | | | | | - |
| 6.3 | | | | | | | | | | | | - |
| 6.4 | | | | | | | | | | | | - |
| 6.5 | | | | | | | | | | | | - |
| 6.6 | | | | | | | | | | | | - |
| 6.7 | | | | | | | | | | | | - |
| 6.8 | | | | | | | | | | | | - |

### Five Highest Paid Salaries

List the names, salaries, and benefits of the five employees who have the highest compensation being claimed on this report.

| Table 7 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Name | Title | % Time Devoted - Administrative | % Time Devoted - Plant Operation, Maintenance, and Security | % Time Devoted - Medical Services | % Time Devoted - Other | Total Time (Must equal 100%) | Salary | Employee Benefits | Payroll Taxes | Workers' Comp. | Gr. Life/Health Ins. | Draw | Other | Total |
| 7.1 | NONE | | | | | | 0.00% | - | | | | | | | - |
| 7.2 | | | | | | | 0.00% | - | | | | | | | - |
| 7.3 | | | | | | | 0.00% | - | | | | | | | - |
| 7.4 | | | | | | | 0.00% | - | | | | | | | - |
| 7.5 | | | | | | | 0.00% | - | | | | | | | - |

## Part II: Condensed Facility Specific Realty Company Financial Information

**NOTE: Reported amount should be the amount reported on the facility specific realty company financial statements.**

| Table 1 | *Income* | | | |
|---|---|---|---|---|
| Line # | Account # | Description | Reported Amount | Explanation |
| 1.1 | 4010.0 | Rent/Interest From Facility Based Income | 0 | |
| 1.2 | 4620.0 | Other Rental Income | | |
| 1.3 | 4630.0 | Other Income | 0 | |
| 1.4 | 4640.0 | Recoverable Fund Asset Income | | |
| **100** | **4000.0** | **Total Income Reported** | **0** | |

| Table 2 | *Expenses* | | | |
|---|---|---|---|---|
| Line # | Account # | Description | Reported Amount | |
| 2.1 | 4540.0 | Real Estate Taxes | 0 | |
| 2.2 | 4630.5 | Personal Property Taxes | 0 | |
| 2.3 | 4640.0 | Long Term Interest (Mortgages & Notes schedule) | 0 | |
| 2.4 | 4635.5 | Working Capital Interest (Mortgages & Notes schedule) | 0 | |
| 2.5 | 4560.0 | Interest on Late Payments, Penalties | | |
| 2.6 | 4647.0 | Other Expenses ** | | Explain: |
| 2.7 | 4660.0 | Depreciation: Building | 0 | |
| 2.8 | 4660.A | Depreciation: Improvements | 0 | |
| 2.9 | 4670.0 | Depreciation: Equipment | 0 | |
| 2.10 | 4670.A | Depreciation: Software/Limited Life Assets | 0 | |
| 2.11 | 4580.0 | Insurance: Building, Building Improvements, Equipment | 0 | |
| 2.12 | 4690.0 | Other Operating Expenses | 0 | Explain: |
| **200** | **4000.0** | **Total Expenses Reported** | **0** | |

| Table 3 | *Assets* | | | |
|---|---|---|---|---|
| Line # | Account # | Description | Reported Amount | |
| 3.1 | 1010.0 | Cash - Checking Account | 0 | |
| 3.2 | 1030.0 | Cash - On hand | 0 | |
| 3.3 | 1020.0 | Cash - Other | 0 | |
| 3.4 | 1100.0 | Loans Receivable - Due from Officers/Owners | 0 | |
| 3.5 | 1170.0 | Loans Receivable - Due from Employees | 0 | |
| 3.6 | 1180.0 | Loans Receivable - Due from Subsidiaries/Affiliates | 0 | |
| 3.7 | 1189.0 | Other Loans Receivable | 0 | |
| 3.8 | 1270.0 | Prepaid Interest | 0 | |
| 3.9 | 1280.0 | Prepaid Insurance | 0 | |
| 3.10 | 1600.0 | Other Prepaid Expenses | 0 | Explain: |
| 3.11 | 1910.0 | Other Current Assets | 0 | Explain: |
| 3.12 | 1610.0 | Land – Cost | 0 | |
| 3.13 | 1620.1 | Building – Cost | 0 | |
| 3.14 | 1622.2 | Building – Accumulated Depreciation | 0 | |
| 3.15 | 1621.1 | Building Improvements – Cost | 0 | |
| 3.16 | 1622.2 | Building Improvements – Accumulated Depreciation | 0 | |
| 3.17 | 1631.1 | Other Improvements – Cost | 0 | |
| 3.18 | 1632.2 | Other Improvements – Accumulated Depreciation | 0 | |
| 3.19 | 1651.1 | Equipment – Cost | 0 | |
| 3.20 | 1652.2 | Equipment – Accumulated Depreciation | 0 | |
| 3.21 | 1701.1 | Motor Vehicles – Cost | 0 | |
| 3.22 | 1702.2 | Motor Vehicles – Accumulated Depreciation | 0 | |
| 3.23 | 1713.1 | Software/Limited-Life Assets - Cost | 0 | |
| 3.24 | 1716.2 | Software/Limited-Life Assets – Accumulated Depreciation | 0 | |
| 3.25 | 1900.0 | Other Deferred Charges and Other Non-Current Assets | 0 | |
| 3.26 | 1970.0 | Intangibles & Goodwill | 0 | |
| 3.27 | 1971.1 | Mortgage Acquisition Cost | 0 | |
| 3.28 | 1971.2 | Accumulated Amortization of Mortgage Acquisition Cost | 0 | |
| **300** | **1000.0** | **Total Assets** | **0** | |

| Table 4 | *Liabilities* | | | |
|---|---|---|---|---|
| Line # | Account # | Description | Reported Amount | |
| 4.1 | 2110.0 | Notes/Loans Payable to Officer, Owner, Related Parties | 0 | |
| 4.2 | 2120.0 | Notes/Loans Payable to Subsidiaries and Affiliates | 0 | |
| 4.3 | 2130.0 | Notes/Loans Payable to Banks | 0 | |
| 4.4 | 2150.0 | Other Short-Term Financing | 0 | |
| 4.5 | 2160.0 | Long-Term Debt, Current Portion * | 0 | |
| 4.6 | 2220.0 | Accrued Taxes – Realty and Management | 0 | |
| 4.7 | 2290.0 | Other Current Liabilities | 0 | |
| 4.8 | 2310.0 | Mortgages * | 0 | |
| 4.9 | 2320.0 | Other Long-Term Debt * | 0 | |
| **400** | | **Total Liabilities** | **0** | |

| Table 5 | *Net Worth* | | | |
|---|---|---|---|---|
| Line # | Account # | Description | Reported Amount | |
| 5.1 | 2510.0 | Proprietorship or Partnership Capital | 0 | |
| 5.2 | 2520.0 | Corporate Shares | 0 | |
| 5.3 | 2530.0 | Partnership/Member's/LLC Shares | 0 | |
| 5.4 | 2540.0 | Contributions | 0 | |
| 5.5 | 2550.0 | Net Profit/(Loss) Year to Date | 0 | |
| 5.6 | 3620.0 | Capital Stock | 0 | |
| 5.7 | 3630.0 | Additional Paid-in Capital | 0 | |
| 5.8 | 3640.0 | Treasury Stock | 0 | |
| 5.9 | 3650.0 | Retained Earnings | 0 | |
| **500** | | **Total Net Worth** | **0** | |
| **600** | | **Total Liabilities and Net Worth** | **0** | **Assets Equals Liabilities and Net Worth** |

## Part III: Facility Specific Realty Company Claimed Fixed Asset Expenses

### Claimed Fixed Asset Depreciation Expenses

Note - This table does not include all fixed assets for the realty company, only those that can be claimed as residential care facility fixed assets. Allowable basis is the portion of fixed assets used for the care of publicly aided residents. Claimed deletions include retired, sold, written-off, damaged, and fully depreciated assets. If the realty company owns fixed assets of other nursing, non-nursing or residential care programs, such as an adult day care program, the related fixed asset expenses must be reported or disallowed on this schedule in column 7 "Non Allowable Depreciation Expense". The allocation methodology for allocating fixed asset expenses must be reported in the Footnotes and Explanations schedule.

| Table 1 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| Line # | Description | Allowable Cost Basis Beginning Balance | Claimed Additions | Claimed Deletions | Allowable Cost Basis Ending Balance | Depreciation % | Depreciation Expense Reported on Financial Statements | Non Allowable Depreciation Expense or Add-Backs | Claimed HCP-2 991 Depreciation Amounts |
| 1.1 | Land HCP-2 | | | | 0 | | | | |
| 1.2 | Building HCP-2 | | | | 0 | | 0 | | 0 |
| 1.3 | Improvements HCP-2 | | | | 0 | 5.00% | 0 | | 0 |
| 1.4 | Equipment HCP-2 | | | | 0 | 10.00% | 0 | | 0 |
| 1.5 | Software (Limited Life Asset) HCP-2 | | | | 0 | 33.33% | 0 | | 0 |
| 100 | **Total Claimed Fixed Asset Depreciation Expense** | 0 | | 0 | 0 | | 0 | 0 | 0 |

### Claimed Other Fixed Asset Expenses

| Table 2 | | 1 |
|---|---|---|
| Line # | Description | Claimed Fixed Asset Expenses - Realty Company (HCP-2 991 |
| 2.1 | Long-Term Interest Claimed * | 0 |
| 2.2 | MA Corporate Excise Tax - Non-Income Section | |
| 2.3 | Building Insurance | 0 |
| 2.4 | Real Estate Taxes | 0 |
| 2.5 | Personal Property Taxes | 0 |
| 2.6 | Other ** | 0 |
| 2.7 | Other Recoverable Fixed Asset Income | |
| 200 | **Total Claimed Fixed Asset Other Expenses** | 0 |

### Total Claimed Fixed Asset Expenses

| Table 3 | | 1 | |
|---|---|---|---|
| Line # | Description | Amount | |
| 300 | Total Claimed Fixed Asset Expenses | 0 | A/C # 9510.1 |

### Detail of Other Operating Expenses A/C # 9502.2

| Table 4 | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| Line # | Describe Expense | Reported Expense | Amount Self Disallowed | Claimed Amount | |
| 4.1 | | 0 | | 0 | |
| 4.2 | | 0 | | 0 | |
| 4.3 | | 0 | | 0 | |
| 4.4 | | 0 | | 0 | |
| 4.5 | | 0 | | 0 | |
| 400 | Total Other Operating Expenses | 0 | 0 | 0 | A/C # 9502.2 |
| | | A/C # 9590.0 | | | |

## Part IV: Facility Specific Realty Company Mortgages and Notes Payable

### SCHEDULE - Mortgages & Notes

IMPORTANT NOTE: Report all mortgages and notes payable whether or not interest expense is incurred on this schedule. Each new note should be reported with all data fields completely filled in. New mortgages or enhancements of existing mortgages must be reported on a separate line. Total Mortgages and Notes as od December 31 and Total Expenses must match amounts reported in Part II Financial Information above.

### Mortgages and Notes Supporting Fixed Assets

| Table 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Line # | Select Type of Notes Payable | Lender Name | Related Party (Select Yes/No) | Date Mortgage Acquired | Due Date | Number of Months Amortized | Monthly Payments | Original Loan Amount | Mortgage Acquisition Costs | Amortization of Mortgage Acquisition Costs (A) | Beginning Loan Balance Jan 1 | Beginning Balance - New Loans | Principal Payments | Pay Off Amount | Pay Off Date | Ending Loan Balance Dec 31 | Interest Rate % | Interest Expense (B) | Period Expenses (C) | Total Fixed Interest (Amortization, Interest and Period Expenses) (A) + (B) + (C) |
| 1.1 | | | | | | | | | | | - | - | 0 | | | 0 | | | | 0 |
| 1.2 | | | | | | | | | | | - | - | 0 | | | 0 | | | | 0 |
| 1.3 | | | | | | | | | | | - | - | 0 | | | 0 | | | | 0 |
| 1.4 | | | | | | | | | | | - | - | | | | 0 | | | | 0 |
| 1.5 | | | | | | | | | | | | | | | | 0 | | | | 0 |
| 1.6 | | | | | | | | | | | | | | | | 0 | | | | 0 |
| 1.7 | | | | | | | | | | | | | | | | 0 | | | | 0 |
| 1.8 | | | | | | | | | | | | | | | | 0 | | | | 0 |
| 100 | TOTALS | | | | | | | | 0 | 0 | | | | | | 0 | | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | Equals Sum of A/C #s 2300.0, 2310.0, and | | | | Equals A/C # 9545.0 |

### Working Capital Debt

| Table 2 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| Line # | Lender Name | Related Party (Select Yes/No) | Beginning Balance - Jan 1 | New Loan Amount | Start Date | Principal Payment | Ending Balance - Dec 31 | Interest Rate % | Interest Expense |
| 2.1 | | | | | | | 0 | | |
| 2.2 | | | | | | | 0 | | |
| 2.3 | | | | | | | 0 | | |
| 2.4 | | | | | | | 0 | | |
| 2.5 | | | | | | | 0 | | |
| 2.6 | | | | | | | 0 | | |
| 200 | TOTALS | | | | | | | | 0 |
| | | | | | | | Equals the sum of A/Cs 2310.0, 2320.0, 2330.0, and 2340.0 | | Equals A/C# 9585.5 |