

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.

Cost Report Schedule and Table Index

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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	5508509
1.2	Provider ID/MMIS ID	
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2023
1.4	Name of Facility	Labelle's Rest Home, Inc.
1.5	Street Address	3 High Street
1.6	City	Shelburne Falls
1.7	Zip	01370
1.8	Telephone	413-625-6560
1.9	Federal Employer Identification Number	04-3401101
1.10	Responsible Person's Name	Haren Upadhyay
1.11	Responsible Person's Email	uharen@yahoo.com
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	Officer
1.13	List Name of Person to Receive Rate Notifications	Willard L Basler
1.14	List Email of Person to Receive Rate Notifications	scoop442@aol.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.	24
1.19	Enter the facility's constructed bed capacity.	32
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)	6/30/1999
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?	Yes
1.27	List realty company name(s) as reported on each realty company cost report.	Haren Upadhyay
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			
1B.2			
1B.3			

Contact Information		
Table 2		1
Line #	Description	
2.1	Contact Person Name	Haren B Upadhyay
2.2	Residential Care Facility or Firm Name	Labelle's Rest Home, Inc.
2.3	Title	President
2.4	Street Address	3 High Street
2.5	City	Shelburne Falls
2.6	State	Mass.
2.7	Zip Code	01370
2.8	Phone Number	413-625-6560
2.9	Email Address	uharen@yahoo.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	Willard L Basler CPA
3.3	Preparer's Affiliation	CPA
3.4	Nursing Facility or Firm Name	Labelle's Rest Home
3.5	Title	n/a
3.6	Street Address	50 Nashua Rd Suite 211
3.7	City	Londonderry
3.8	State	NH
3.9	Zip Code	03053
3.10	Phone Number	603-432-1166
3.11	Email Address	scoop442@aol.com
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	Upadhyay, Haren	3 High St. Shelburne Falls, Ma. 01370	100.0%	Person	Direct
1.2					
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	N/A				
2.2					
2.3					
2.4					
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	Other	Facility	1,528,432	various	1,506,197	Owner	Haren Upadhyay
3.2	Note	Facility	5,000	various	5,000	Owner	Haren Upadhyay
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	Haren Upadhyay		70,000		70,000	4130.1	Haren Upadhyay	100.00%
4.2					-			
4.3					-			
4.4					-			
4.5					-			
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	Officer	Haren Upadhyay	President	100.00%	70,000							70,000
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	Carole Musante	CS Coordinator	25.00%	10.00%	65.00%		100.00%	35,360		3,100	400				38,860
6.2	Katie Horzyl	Manager	50.00%	25.00%	25.00%		100.00%	31,455		2,650	350				34,455
6.3	Diana Rivera	N.A./R.P.	10.00%	40.00%	50.00%		100.00%	30,993		2,600	350				33,943
6.4	Megrady Crossman	Dietary	100.00%				100.00%	30,667		2,550	350				33,567
6.5	Wolly Musante	N.A./R.P.	10.00%	40.00%	50.00%		100.00%	26,385		2,150	300				28,835

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	15,866
1.2	1030.0	Cash - On Hand	
1.3	1040.0	Temporary Investments	
1.4	1050.0	Other Cash	
1.100	1010.0	Total Cash and Cash Equivalents	15,866
		Accounts Receivable	
1.5	1080.0	Private Patients	
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	19,850
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	19,850
		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	35,716

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			0
2.2	1520.0	Building			0
2.3	1610.0	Building Improvements			0
2.4	1625.0	Leasehold Improvements	184,499	(128,627.00)	55,872
2.5	1630.0	Other Improvements			0
2.6	1650.0	Equipment	62,153	(55,623.00)	6,530
2.7	1700.0	Motor Vehicles	54,231	(54,231.00)	0
2.8	1710.0	Software/Limited Life Assets			0
200	1500.0	Total Non-Current Fixed Assets			62,402

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	98,118

Current Liabilities

Table 4			1
Line #	Account #	Description	Account Balance
		Accounts Payable	
4.1	2020.0	Trade Payables	3,500
4.2	2030.0	Accrued Expenses	1,500
4.3	2047.0	Due to Commonwealth of MA	
4.100	2010.0	Total Accounts Payable	5,000
4.4	2050.0	Patient Funds Due	
		Notes and Loans Payable (See Mortgages & Notes Schedule)	
4.5	2110.0	Officer, Owner, or Related Parties	1,506,197
4.6	2120.0	Subsidiaries and Affiliates	
4.7	2130.0	Banks	5,000
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	1,511,197
		Accrued Salaries and Payroll Liabilities	
4.11	2190.0	Accrued Salaries	
4.12	2200.0	Accrued Payroll Tax Withheld	3,500
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	3,500
		Other Current Liabilities	
4.15	2260.0	State and Federal Taxes Payable	581
4.16	2270.0	Accrued Interest Payable	
4.17	2290.0	Other Current Liabilities	
4.400	2250.0	Total Other Current Liabilities	581
400	2005.0	Total Current Liabilities	1,520,278

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	1,520,278

Net Worth			
Table 6			1
Line #	Account #	Description	Account Balance
		Proprietorship or Partnership Capital	
6.1	2520.0	Capital	100
6.2	2530.0	Proprietor Drawings	
6.3	2540.0	Partner Drawings	
6.4	2550.0	Net Profit(Loss) - Current Year	12,432
6.100	2510.0	Total Proprietorship or Partnership Capital	12,532
6.5	2620.0	Capital Stock	
6.6	2630.0	Additional Paid in Capital	
6.7	2640.0	Treasury Stock	
6.8	2650.0	Retained Earnings	(1,434,692)
6.200	2610.0	Total Corporation Capital	(1,434,692)
600	2000.0	Total Liabilities and Net Worth	98,118

Balance Sheet Check			
Table 7			1
Line #	Account #	Description	Account Balance
7.1	1000.0	Total Assets	98,118
7.2	2000.0	Total Liabilities and Net Worth	98,118
		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

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

Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1				
2A.2				
2A.3				
2A.4				
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.300		Total Clerical Salaries		0

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

Table 2B - Detail of Other Accounting Expenses																						
Part I: Purchased Service Accounting Expenses																						
Line #	Vendor Name	Date Occurred (MM/DD/YYYY)	Amount	Select Code	Brief Description of Service																	
28.1	Willard L. Basler CPA	8/15/2024	1,500	A	7/balance Cost Report Prep																	
28.2	Charles Keelby	12/31/2023	1,000	H	Bookkeeping service																	
28.3																						
28.4																						
28.5																						
28.100		Sub-Total	2,500																			
Part II: Employee's Responsibilities Only																						
Line #	Employee Name	Job Title	Salary	Select Code	Description of Responsibilities	% of time																
28.6																						
28.7																						
28.8																						
28.9																						
28.100		Sub-Total	0																			
28.200		Total Other Accounting	2,500																			
<table><tr><th colspan="4">Accounting Expense Codes</th></tr><tr><td>A. HCF-4 Cost Report Prep</td><td>D. Personal Tax Prep</td><td>G. SEC Filings</td><td></td></tr><tr><td>B. Medicare Cost Report Prep</td><td>E. Management Advisory Services</td><td>H. Other Allowable Accounting (Explain)</td><td></td></tr><tr><td>C. Corporate Tax Prep</td><td>F. Certified Financial Statement Audit</td><td>I. Other Non-Allowable Accounting (Explain)</td><td></td></tr></table>							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)	
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 I and/or I.1:																						

2.42	4510.8	Real Estate Taxes			0	0
2.43	4515.8	Personal Property Taxes*			0	0
2.44	4520.8	Interest Long-Term (See Mortgages & Notes Schedule)			0	0
2.45	4535.8	Rent - Real Property	11,453		(11,453)	0
2.46	4538.8	Other Rent (Use Table 2D to Right to Itemize Expenses)			0	0
2.47	4550.8	Depreciation - Building	0		0	0
2.48	4565.8	Depreciation - Building Improvements			0	0
2.49	4567.8	Depreciation - Leasehold Improvements	7,060		(7,060)	0
2.50	4568.8	Depreciation - Other Improvements			0	0
2.51	4570.8	Depreciation - Equipment	1,410		(1,410)	0
2.52	4585.8	Depreciation - Software/Limited Life Assets			0	0
2.1400	4540.0	Total Fixed Costs	19,923		(19,923)	0
Plant Operation, Maintenance & Security						
2.53	5105.1	Plant Operations, Maintenance & Security - Salaries	31,435			31,435
2.54	5110.1	Plant Operations, Maintenance & Security - Purchased Service	21,081			21,081
2.55	5115.1	Plant Operations, Maintenance & Security - Supplies and Expenses	7,911			7,911
2.56	5120.1	Plant Operations, Maintenance & Security - Utilities	33,442			33,442
2.57	5125.1	Plant Operations, Maintenance & Security - Deprec.	5,224			5,224
2.1500	5100.0	Total Plant Operation, Maintenance & Security	99,193	0		99,193
Dietary						
2.58	5205.1	Dietary - Salaries	34,876			34,876
2.59	5210.1	Dietary - Food	64,731			64,731
2.60	5215.1	Dietary - Purchased Service	1,083			1,083
2.61	5216.1	Dietician - Salary				0
2.62	5218.1	Dietician - Purchased Service				0
2.63	5219.1	Dietary - Supplies and Expenses				0
2.1600	5200.0	Total Dietary	100,690	0		100,690
Laundry						
2.64	5310.1	Laundry - Salaries				0
2.65	5320.1	Laundry - Purchased Service				0
2.66	5330.1	Laundry - Supplies and Expenses				0
2.67	5340.1	Laundry - Linen and Bedding				0
2.1700	5300.0	Total Laundry	0	0		0
Housekeeping						
2.68	5410.1	Housekeeping - Salaries				0
2.69	5415.1	Housekeeping - Purchased Service				0
2.70	5420.1	Housekeeping - Supplies and Expenses				0
2.1800	5400.0	Total Housekeeping	0	0		0
Nursing						
Registered Nurses						
2.71	6030.1	RN Salaries				0
2.72	6035.1	RN Purchased Service	800			800
2.73	6041.1	LPN Salaries				0
2.74	6042.1	LPN Purchased Service				0
Nurses Aides						
2.75	6051.1	Nurses Aides Salaries	129,465			129,465
2.76	6052.1	Nurses Aides Purchased Service				0
2.1900	6000.0	Total Nursing	130,265	0		130,265
Medical Services						
2.77	6504.1	Quality Assurance Professional				0
2.78	6507.1	Community Support Coordinator	35,360			35,360
Physician Services						
2.79	6514.3	Employee Physicals				0
2.80	6515.3	Other Medical Services Expenses (Use Table 2E to Right to Itemize Expenses)	0			0
2.2000	6510.0	Total Physician Services	0	0		0
Medical Supplies & Drugs						
2.81	6530.5	Legend Drugs			0	0
2.82	6532.5	Infuse Supplies Not Reused	2,870			2,870
2.83	6533.5	Resold to Private Patients				0
2.2100	6530.0	Total Medical Supplies and Drugs	2,870	0	0	2,870
2.84	6535.0	Pharmacy Consults				0
2.85	6540.0	Social Service Worker (Including Behavioral Health)	7,696			7,696
2.2200	6500.0	Total Medical Services	45,926	0	0	45,926
Restorative & Recreational Therapy						
Restorative Therapy						
2.86	7011.1	Indirect Restorative Therapy Salaries				0
2.87	7012.1	Direct Restorative Therapy Salaries				0
2.88	7012.2	Direct Restorative Therapy Benefits				0
2.89	7013.1	Indirect Restorative Therapy Consultants				0
2.90	7014.1	Direct Restorative Therapy Consultants				0
2.2300	7010.0	Total Restorative Therapy	0	0		0
Recreational Therapy						
2.91	7021.1	Recreational Therapy - Salaries	886			886
2.92	7021.3	Recreational Therapy - Purchased Service	5,725			6,611
2.93	7023.5	Recreational Therapy - Supplies and Expenses	9,550			15,075
2.94	7024.8	Recreational Therapy - Transportation				0
2.2400	7020.0	Total Recreational Therapy	15,961	0	0	6,611
2.2500	7000.0	Total Restorative & Recreational Therapy	15,961	0	0	6,611
Bad Accts - Taxes-Refunds-Day Care						
2.95	8010.0	Bad Accounts - Refunds, Taxes, Day Care			0	0
2.96	8015.0	Fines, Late Charges, and Penalties				0
2.97	8025.0	State & Federal Income Taxes	456		(456)	0
2.98	8027.7	Massachusetts Excise Tax				0
2.99	8030.0	Refunds and Allowances				0
2.101	8040.0	Adult Day Care Costs*				0
2.102	8050.0	Other Non-Nursing Costs*				0
2.2600	8000.0	Total Bad Accts - Taxes-Refunds-Day Care	456		(456)	0
200	4000.0	Total Expenses		527,187	0	(25,379)
			A/C # 4000.0	A/C #9945.0	A/C # 9939.0	##P#

Table 2C: Detail of Other Operating Expenses		
Line #	Description	Amount
2C.1		
2C.3		
2C.4		
2C.100	Total	0

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		
2E.2		
2E.3		
2E.4		
2E.100	Total	0

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses		
Table 3		1
Line #	Account #	Description
8.1	9040.0	Total Reported Operating Expenses
8.2	9945.0	Less: Self-Disallowed Expenses
8.3	9939.0	Less: Automatically Disallowed Expenses
8.100	4001.1	Total Non-Allowable Expenses
8.4	9960.3	Allocated Administrative and General from Management Company (MCF-3)
8.5	9962.2	Other Operating Expense Add-Back from Realty Company (MCF-2 RV)
8.6	9963.3	Allocated Other Operating Expense Add-Back from Management Company
8.7	9961.3	Allocated Fixed Asset Expenses from Management Company (MCF-3)
8.8	9950.0	Claimed Fixed Asset Expenses from Claimed Fixed Assets Schedule
8.9	9952.8	Allocated Direct Variable (Dedictary, Indirect Therapy & C&I) Management Company Add-Back Expenses
8.10	9952.8	Allocated Direct Director of Nurses Management Company Add-Back Expenses
8.200	4061.2	Total Allowable Add-Back Expenses
8.41	NA	Less: Recoverable Income (inflating operating expenses)
800	4002.0	Total Allowable Operating Expenses Claimed

Reconciliation of Cost Report Net Income to Financial Statement (Book) Net Income		
Table 4		1
Line #	Account #	Description
Cost Report Net Income		
4.1	3000.0	Total Cost Report Income
4.2	4000.0	Total Cost Report Expenses
4.100		Net Income (Less) Cost Report
Financial Statement Net Income		
4.3		Financial Statement Reported Income
4.4		Financial Statement Reported Expenses
4.200		Net Income (Less) Financial Statement
Variance		
4.5		Variance Between Cost Report and Financial Statements: Income
4.6		Variance Between Cost Report and Financial Statements: Expenses
4.7		Variance Between Cost Report and Financial Statements: Net Income
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
4.100		Total Reconciling Items
Reconciliation		
400		Difference between Total Reconciling Items and Variance Between Cost Report and Financial Statements: Net Income ***

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	1,080
1.2	0212.5 & 0212.0	Massachusetts EAEDC	
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	1,080

Resident Days April 1 - June 30

Table 2	Account #		1
Line #		Payer Description	Reported Days
2.1	0310.5 & 0310.0	DTA Days	1,032
2.2	0312.5 & 0312.0	Massachusetts EAEDC	
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	1,032

Resident Days July 1 - September 30

Table 3	Account #		1
Line #		Payer Description	Reported Days
3.1	0410.5 & 0410.0	DTA Days	1,164
3.2	0412.5 & 0412.0	Massachusetts EAEDC	
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	1,164

Resident Days October 1 - December 31			
Table 4	Account #		1
Line #		Payer Description	Reported Days
4.1	0510.5 & 0510.0	DTA Days	1,196
4.2	0512.5 & 0512.0	Massachusetts EAEDC	
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	1,196

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	4,472
5.2	0612.5 & 0612.0	Massachusetts EAEDC	0
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	4,472

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	1
6.3	0170.0	Number of Public Community Support Admissions	3
6.4	0175.0	Number of Total Community Support Admissions	3
6.5	0180.0	Public Community Support Resident Days	4,472
6.6	0182.0	Private Community Support Resident Days	
600	0185.0	Total Community Support Resident Days	4,472

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				0					
1.2	Land HCF-2	1,500			1,500					
1.3	Building HCF-4				0					0
1.4	Building HCF-2	57,583			57,583	2.50%			2,015	2,015
1.5	Improvements HCF-4	170,136	14,363		184,499	5.00%	7,060			7,060
1.6	Improvements HCF-2	45,189			45,189	5.00%			-	0
1.7	Equipment HCF-4	111,196	5,189		116,385	10.00%	1,410			1,410
1.8	Equipment HCF-2				0	10.00%			-	0
1.9	Software/Limited Life Assets HCF-4				0	33.33%				0
1.10	Software/Limited Life Assets HCF-2				0	33.33%			-	0
100	Total Claimed Fixed Asset Depreciation Expense	385,604	19,552	0	405,156		8,470	0	2,015	10,485

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
2.2	MA Corporate Excise Tax - Non-Income Portion		456	456
2.3	Building Insurance		4,601	4,601
2.4	Real Estate Taxes		6,302	6,302
2.5	Personal Property Taxes		-	0
2.6	Other Claimed Fixed Assets**		550	550
200	Total Claimed Fixed Asset Other Expenses	0	11,909	11,909

Total Claimed Fixed Asset Expenses			
Table 3		1	
Line #	Description	Total	
300	Total Fixed Assets Expenses Claimed	22,394	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)	
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?		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.		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	Haren Upadhyay	Yes	1,528,432	(22,235)			1,506,197		
2.2	T D Banknorth	No	5,000				5,000		
2.3							-		
2.4							-		
2.5							-		
2.6							-		
200	TOTALS						1,511,197		-

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	00,000.0						
		7110.2	7210.2	7310.2	4306.1	7410.2	7510.2	7610.2
1.2	Maintenance Staff	00,001.0	1.0	2000.0	31,455			
		7111.2	7211.2	7311.2	5105.1	7411.2	7511.2	7611.2
1.3	Dietary Staff	00,001.3	1.2	2600.0	34,876			
		7112.2	7212.2	7312.2	5205.1	7412.2	7512.2	7612.2
1.4	Dietician	00,000.0						
		7113.2	7213.2	7313.2	5231.1	7413.2	7513.2	7613.2
1.5	Laundry Staff	00,000.0						
		7114.2	7214.2	7314.2	5310.1	7414.2	7514.2	7614.2
1.6	Housekeeping Staff	00,000.0						
		7115.2	7215.2	7315.2	5410.1	7415.2	7515.2	7615.2
1.7	Quality Assurance	00,000.0						
		7116.2	7216.2	7316.2	6504.1	7416.2	7516.2	7616.2
1.8	Community Support Coordinator	00,001.0	1.0	2080.0	35,360			
		7119.2	7219.2	7319.2	6507.1	7419.2	7519.2	7619.2
1.9	Social Services Staff	00,000.1	0.3	300.0	7,696			
		7120.2	7220.2	7320.2	6540.0	7420.2	7520.2	7620.2
1.10	Restorative - Indirect Salaries	00,000.0						
		7121.2	7221.2	7321.2	7011.1	7421.2	7521.2	7621.2
1.11	Restorative - Direct Salaries	00,000.0						
		7122.2	7222.2	7322.2	7012.1	7422.2	7522.2	7622.2
1.12	Recreational Staff	00,000.0	0.1		866			
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,001.0	1.0	2000.0	70,000			
		7124.2	7224.2	7324.2	4110.1	7424.2	7524.2	7624.2
1.14	Officer	00,000.0						
		7125.2	7225.2	7325.2	4125.1	7425.2	7525.2	7625.2
1.15	Clerical Staff	00,000.0						
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	00,000.0	0.1	20.0	800			
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	00,000.0						
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,005.0	10.5	10500.0	129,465			
		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

1

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.

[illegible]

[illegible]

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	Willard L Basler CPA
1.2	Preparer's Last Name	Basler
1.3	Preparer's First Name	Willard
1.4	Preparer's Middle Name	L
1.5	Title	CPA
1.6	Street Address	50 Nashua Rd. Suite 211
1.7	City	Londonderry
1.8	State	NH
1.9	Zip Code	03053
1.10	Phone Number	603-432-1166
1.11	Email Address	scoop442@aol.com
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:	8/23/2024



Certification by Owner, Partner, or Officer

Table 2		1
2.1	Last Name	Upadhyay
2.2	First Name	Haren
2.3	Middle Name	
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	8/23/2024

☒

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

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

The HCF-2 RW must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 6535.3 "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 RW 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	Entity Company Name	Parent Location
1.2	ESN	
1.3	Entity Company OSHA #	
1.4	Balance Sheet Date	12/31/2016
1.5	Entity Company Address	8740 Stewart
1.6	City	Chattanooga, TN
1.7	State	Georgia
1.8	Telephone	423-435-4900

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 in any partnership, joint venture, corporation or other entity; and 2) An indirect beneficial owner is defined as a person having any rights or benefits 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?
1.1	Quaffaine, Martin	1 High Street Burlington Park, Mass. 05405	100%	Direct	Direct
2.1					
2.2					
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
1500 F	Nursing and/or Rest Home	UPN	Name of Owner	Company Address	% Ownership
1.1	N/A				
1.2					
1.3					
1.4					
1.5					

Indebtedness

List any indebtedness (mortgages, deeds, trust instruments, notes, or other financial information) of (i) 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 #	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	UKT Owner's Name
0.1							
0.2							
0.3							
0.4							
0.5							

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.)

1	2	3	4	5	6	7	8
Line #	Billing Period	Goods/Services	Billing Compensation	Mark up	Cost	Account Pctd	% Ownership
3.1							
3.2							
3.3							
3.4							
3.5							
3.6							

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.

[illegible]

Five Highest Paid Salaries

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

[illegible]

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	Supplement
1.0	0000	Income Statement - Total Income	11,451.5	
1.1	0001	Operating Income	11,451.5	
1.2	0002	Non-Operating Income	0.00	
1.3	0003	Total Income	11,451.5	
1.4	0004	Total Income	11,451.5	
1.5	0005	Total Income	11,451.5	
1.6	0006	Total Income	11,451.5	
1.7	0007	Total Income	11,451.5	
1.8	0008	Total Income	11,451.5	
1.9	0009	Total Income	11,451.5	
1.10	0010	Total Income	11,451.5	
1.11	0011	Total Income	11,451.5	
1.12	0012	Total Income	11,451.5	
1.13	0013	Total Income	11,451.5	
1.14	0014	Total Income	11,451.5	
1.15	0015	Total Income	11,451.5	
1.16	0016	Total Income	11,451.5	
1.17	0017	Total Income	11,451.5	
1.18	0018	Total Income	11,451.5	
1.19	0019	Total Income	11,451.5	
1.20	0020	Total Income	11,451.5	
1.21	0021	Total Income	11,451.5	
1.22	0022	Total Income	11,451.5	
1.23	0023	Total Income	11,451.5	
1.24	0024	Total Income	11,451.5	
1.25	0025	Total Income	11,451.5	
1.26	0026	Total Income	11,451.5	
1.27	0027	Total Income	11,451.5	
1.28	0028	Total Income	11,451.5	
1.29	0029	Total Income	11,451.5	
1.30	0030	Total Income	11,451.5	
1.31	0031	Total Income	11,451.5	
1.32	0032	Total Income	11,451.5	
1.33	0033	Total Income	11,451.5	
1.34	0034	Total Income	11,451.5	
1.35	0035	Total Income	11,451.5	
1.36	0036	Total Income	11,451.5	
1.37	0037	Total Income	11,451.5	
1.38	0038	Total Income	11,451.5	
1.39	0039	Total Income	11,451.5	
1.40	0040	Total Income	11,451.5	
1.41	0041	Total Income	11,451.5	
1.42	0042	Total Income	11,451.5	
1.43	0043	Total Income	11,451.5	
1.44	0044	Total Income	11,451.5	
1.45	0045	Total Income	11,451.5	
1.46	0046	Total Income	11,451.5	
1.47	0047	Total Income	11,451.5	
1.48	0048	Total Income	11,451.5	
1.49	0049	Total Income	11,451.5	
1.50	0050	Total Income	11,451.5	
1.51	0051	Total Income	11,451.5	
1.52	0052	Total Income	11,451.5	
1.53	0053	Total Income	11,451.5	
1.54	0054	Total Income	11,451.5	
1.55	0055	Total Income	11,451.5	
1.56	0056	Total Income	11,451.5	
1.57	0057	Total Income	11,451.5	
1.58	0058	Total Income	11,451.5	
1.59	0059	Total Income	11,451.5	
1.60	0060	Total Income	11,451.5	
1.61	0061	Total Income	11,451.5	
1.62	0062	Total Income	11,451.5	
1.63	0063	Total Income	11,451.5	
1.64	0064	Total Income	11,451.5	
1.65	0065	Total Income	11,451.5	
1.66	0066	Total Income	11,451.5	
1.67	0067	Total Income	11,451.5	
1.68	0068	Total Income	11,451.5	
1.69	0069	Total Income	11,451.5	
1.70	0070	Total Income	11,451.5	
1.71	0071	Total Income	11,451.5	
1.72	0072	Total Income	11,451.5	
1.73	0073	Total Income	11,451.5	
1.74	0074	Total Income	11,451.5	
1.75	0075	Total Income	11,451.5	
1.76	0076	Total Income	11,451.5	
1.77	0077	Total Income	11,451.5	
1.78	0078	Total Income	11,451.5	
1.79	0079	Total Income	11,451.5	
1.80	0080	Total Income	11,451.5	
1.81	0081	Total Income	11,451.5	
1.82	0082	Total Income	11,451.5	
1.83	0083	Total Income	11,451.5	
1.84	0084	Total Income	11,451.5	

Assets Equals Liabilities and Net Worth

Table 1	1	2	3	4	5	6	7	8
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