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	550-1547
1.2	Provider ID/MMIS ID	110062889 A
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2023
1.4	Name of Facility	Lathrop Home
1.5	Street Address	215 South St.
1.6	City	Northampton
1.7	Zip	01060
1.8	Telephone	413-584-2865
1.9	Federal Employer Identification Number	042 104 372
1.10	Responsible Person's Name	Tracy Carroll
1.11	Responsible Person's Email	tracy@lathrophome.org
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	Officer
1.13	List Name of Person to Receive Rate Notifications	Tracy Carroll
1.14	List Email of Person to Receive Rate Notifications	tracy@lathrophome.org
1.15	Status (Select Profit/Non-Profit from Dropdown Menu)	Non-Profit
1.16	Legal Status (Select from Dropdown Menu)	8. Other Non-Profit
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.	39
1.19	Enter the facility's constructed bed capacity.	42
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)	10/17/1884
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	N/A
1.25	If line 1.23 is Yes, list the name of the management company as reported on	N/A
1.26	Are you completing the HCF-2 RA (Realty Company Report) Tab in this Excel	No
1.27	List realty company name(s) as reported on each realty company cost report.	N/A
1.28	Does the Balance Sheet schedule include any capitalized leases reported as	No
1.29	Does the Profit Loss schedule include any expenses that have not been paid	No
1.30	Does the Profit Loss schedule include any expenses for services or non-paid	No
1.31	Do you report any employee's sala[illegible] in more than one expense account? If	Yes
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	No

Other Business Activities

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

Bed License Information

Table 1B	1	2	3
Line #	Date From	Date To	# of Beds
1B.1	1/1/2023	12/31/2023	39
1B.2			
1B.3			

Contact Information

Table 2		1
Line #	Description	
2.1	Contact Person Name	Tracy Carroll
2.2	Residential Care Facility or Firm Name	Lathrop Home
2.3	Title	Business Office Manager
2.4	Street Address	215 South St.
2.5	City	Northampton
2.6	State	MA
2.7	Zip Code	01060
2.8	Phone Number	413-584-2865
2.9	Email Address	tracy@lathrophome.org

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	Shannon Howell
3.3	Preparer's Affiliation	Business Director
3.4	Nursing Facility or Firm Name	Lathrop Home
3.5	Title	Business Director
3.6	Street Address	215 South Street
3.7	City	Northampton
3.8	State	MA
3.9	Zip Code	01060
3.10	Phone Number	413-584-2865
3.11	Email Address	shannon@lathrophome.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	N/A				
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							
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	N/A				-			
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												-
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	Tracy Carroll	Executive Director	75.00%	25.00%			100.00%								-
6.2	Shannon Howell	Business Director	100.00%				100.00%								-
6.3	Robert Laptew	Specialist			100.00%		100.00%								-
6.4	Linda Thouin Quinn	Director of Nursing	25.00%		75.00%		100.00%								-
6.5	Elizabeth Kelly	Charge Nurse			100.00%		100.00%								-

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	120,453
1.2	1030.0	Cash - On Hand	
1.3	1040.0	Temporary Investments	200,573
1.4	1050.0	Other Cash	
1.100	**1010.0**	**Total Cash and Cash Equivalents**	**321,026**
		Accounts Receivable	
1.5	1080.0	Private Patients	11,238
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	148,632
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**	**159,870**
		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	68,640
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**	**68,640**
1.21	1310.0	Other Current Assets	70,500.00
100	**1005.0**	**Total Current Assets**	**620,036**

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	6,000		**6,000**
2.2	1520.0	Building	246,000	(241,900.00)	**4,100**
2.3	1610.0	Building Improvements	1,991,008	(958,030.00)	**1,032,978**
2.4	1625.0	Leasehold Improvements			**0**
2.5	1630.0	Other Improvements	60,935	(16,048.00)	**44,887**
2.6	1650.0	Equipment	231,170	(171,736.00)	**59,434**
2.7	1700.0	Motor Vehicles			**0**
2.8	1710.0	Software/Limited Life Assets			**0**
200	**1500.0**	**Total Non-Current Fixed Assets**			**1,147,399**

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 **	4,761,574
3.100	**1900.0**	**Total Deferred Charges and Other Assets**	**4,761,574**
300	**1000.0**	**Total Assets**	**6,529,009**

Current Liabilities			
Table 4			1
Line #	Account #	**Description**	**Account Balance**
		Accounts Payable	
4.1	2020.0	Trade Payables	(2,474)
4.2	2030.0	Accrued Expenses	-
4.3	2047.0	Due to Commonwealth of MA	
4.100	**2010.0**	**Total Accounts Payable**	**(2,474)**
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	6,369
4.10	2160.0	Payment Due Within One Year on Long-Term Debt *	
4.200	**2100.0**	**Total Notes and Loans Payable**	**6,369**
		Accrued Salaries and Payroll Liabilities	
4.11	2190.0	Accrued Salaries	84,335
4.12	2200.0	Accrued Payroll Tax Withheld	
4.13	2210.0	Accrued Employee Taxes Payable	3,649
4.14	2220.0	Other Payroll Liabilities	45,353
4.300	**2180.0**	**Total Accrued Salaries and Payroll Liabilities**	**133,337**
		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	34,803
4.400	**2250.0**	**Total Other Current Liabilities**	**34,803**
400	**2005.0**	**Total Current Liabilities**	**172,035**

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**	**172,035**

Net Worth			
Table 6			1
Line #	Account #	**Description**	**Account Balance**
		Proprietorship or Partnership Capital	
6.1	2520.0	Capital	
6.2	2530.0	Proprietor Drawings	
6.3	2540.0	Partner Drawings	
6.4	2550.0	Net Profit(Loss) - Current Year	526,742
6.100	**2510.0**	**Total Proprietorship or Partnership Capital**	**526,742**
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	5,830,232
6.200	**2610.0**	**Total Corporation Capital**	**5,830,232**
600	**2000.0**	**Total Liabilities and Net Worth**	**6,529,009**

Balance Sheet Check

Table 7			1
Line #	Account #	Description	Account Balance
7.1	1000.0	Total Assets	6,529,009
7.2	2000.0	Total Liabilities and Net Worth	6,529,009
		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			1
Line #	Account #	Description	Reported Amount
1.1	3021.1	Private	210,134
1.2	3022.5	DTA	2,175,990
1.3	3022.6	MA DTA Patient Resource Income	
1.4	3022.7	Non-MA DTA	
1.5	3023.1	MA Commission for the Blind	
1.6	3023.2	VA and Other Public	
1.7	3025.3	Adult Day Care Income	
1.8	3026.2	Other Non-Nursing Income	4,543
1.9		COVID-Related Supplemental Payments	231,776
		Ancillary Services (Use Table 1A to Right to Itemize Expenses)	
1.10	3031.1	Private	
1.11	3032.5	Medicaid (DMA)	
1.12	3032.7	Non-MA Medicaid	
1.13	3033.1	MA Commission for the Blind	
1.14	3033.2	VA & Other Public	
1.100	**3030.0**	**Total Ancillary Services**	**0**
		Miscellaneous and Recoverable Income	
1.15	3120.0	Endowment & Other Nonrecoverable **	(107,730)
1.16	3140.0	Laundry Recoverable Income	
1.17	3150.0	Vending Machines Recoverable Income	
1.18	3160.0	Bad Debt Recovery	
1.19	3170.0	Prior Year Retroactive Adjustment	
1.20	3180.0	Interest Income	1,965
1.21	3194.0	Operating Costs Recoverable	
1.22	3196.0	Fixed Costs Recoverable	
1.200	**3130.0**	**Total Miscellaneous and Recoverable Income**	**(105,765)**
100	**3000.0**	**Total Gross Income**	**2,516,678**

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			1	2	3	4
Line #	Account #	Description	Reported	Jeff	Automatically	Total Allowable
		Administrative Expenses				
2.1	4110.1	Administrative/Responsible Person Salaries	89,793			89,793
2.2	4125.1	Officer Salaries*			0	0
		Other Expenses				
2.3	4140.1	Clerical Salaries (Use Table 2A to Right to Itemize Salaries)	80,342			80,342
2.4	4150.3	Electronic Data Processing, Payroll, and Bookkeeping Services	57,593			57,593
2.5	4160.3	Management Fees	26,175		(26,175)	0
2.6	4160.6	Management Consultants*			0	0
2.100	**4130.1**	**Total Other Expenses**	**164,110**	**0**	**(26,175)**	**137,935**
2.200	**4100.0**	**Total Administrative Expenses**	**253,903**	**0**	**(26,175)**	**227,728**
		General Supplies & Expenses				
2.7	4250.5	Office Supplies	6,564			6,564
2.8	4261.5	Phone	1,885			1,885
2.90	4262.6	Directory Advertising			0	0
2.300	**4260.0**	**Total Telephone Expenses**	**1,885**	**0**	**0**	**1,885**
		Travel Expenses				
2.10	4275.5	Motor Vehicle Expense*	2,359			2,359
2.11	4280.5	Conventions and Meetings				0
2.400	**4270.5**	**Total Travel Expenses**	**2,359**	**0**		**2,359**
		Advertising Expenses				
2.12	4295.7	Help Wanted	6,901			6,901
2.13	4298.7	Promotional	3,926		(3,926)	0
2.500	**4290.0**	**Total Advertising Expenses**	**10,827**	**0**	**(3,926)**	**6,901**
		Licenses and Dues Expenses				
2.14	4301.7	Licenses and Dues: Patient Care Related Portion	4,836			4,836
2.15	4302.3	Licenses and Dues: Not Related to Patient Care	2,646		(2,646)	0
2.600	**4300.0**	**Total Licenses and Dues Expenses**	**7,482**	**0**	**(2,646)**	**4,836**
		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
2.19	4306.4	Job Related Education	573			573
2.700	**4305.0**	**Total Education and Training Expenses**	**573**	**0**		**573**
		Employee Benefits				
2.20	4310.1	Employee Benefits - Pensions **	21,282			21,282
2.21	4310.2	Employee Benefits - Other	6,013			6,013
2.22	4339.2	Officer Profit Sharing and Other Benefits			0	0
2.800	**4310.0**	**Total Employee Benefits**	**27,295**	**0**	**0**	**27,295**
		Accounting Expenses				
2.23	4350.3	Accounting: Appeal Services			0	0
2.24	4360.3	Accounting: Other (Use Table 2B to Right to Itemize Expenses)	3,890			3,890
2.900	**4340.0**	**Total Accounting Expenses**	**3,890**	**0**	**0**	**3,890**
		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	156,135			156,135
2.29	4411.2	Payroll Taxes - Officers			0	0
2.1100	**4400.0**	**Total Payroll Taxes**	**156,135**	**0**	**0**	**156,135**
		Insurance Expense				
2.30	4428.7	Insurance: Department of Unemployment Assistance Claims (DUA) - A&G Portion				0
2.31	4431.7	Insurance: Malpractice and General Liability *	41,231			41,231
2.32	4432.7	Key Person Insurance			0	0
2.33	4590.8	Insurance: Building Improvements and Equipment	13,303		(13,303)	0
2.34	4424.1	Workers' Comp - Other	27,486			27,486
2.35	4424.2	Workers' Comp - Officers			0	0
2.36	4426.1	Group Life/Health - Other	122,580			122,580
2.37	4426.2	Group Life/Health - Officers			0	0
2.1200	**4420.0**	**Total Insurance Expenses**	**204,600**	**0**	**(13,303)**	**191,297**
2.38	4415.0	Interest on Late Payments, Penalties			0	0
2.39	4430.0	Interest on Working Capital			0	0
2.40	4435.0	Pre-Opening Expenses			0	0
2.41	4443.00	Other Operating Expenses (Use Table 2C to Right to Itemize Expenses)	0			0
2.1300	**4200.0**	**Total General Supplies and Expenses**	**421,610**	**0**	**(19,875)**	**401,735**
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			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			0	0
2.48	4565.8	Depreciation - Building Improvements			0	0
2.49	4567.8	Depreciation - Leasehold Improvements			0	0
2.50	4568.8	Depreciation - Other Improvements			0	0
2.51	4570.8	Depreciation - Equipment			0	0
2.52	4585.8	Depreciation - Software/Limited Life Assets			0	0
2.1400	**4540.0**	**Total Fixed Costs**	**0**		**0**	**0**
		Plant Operation, Maintenance & Security				
2.53	5105.1	Plant Operations, Maintenance & Security - Salaries	78,999			78,999
2.54	5110.3	Plant Operations, Maintenance & Security - Purchased Service	27,928			27,928
2.55	5115.5	Plant Operations, Maintenance & Security - Supplies and Expenses	42,531			42,531
2.56	5120.5	Plant Operations, Maintenance & Security - Utilities	82,240			82,240
2.57	5130.7	Plant Operations, Maintenance & Security - Repairs	27,163			27,163
2.1500	**5100.0**	**Total Plant Operation, Maintenance & Security**	**258,861**	**0**		**258,861**
		Dietary				
2.58	5205.1	Dietary - Salaries	351,125			351,125
2.59	5220.5	Dietary - Food	112,082			112,082
2.60	5221.3	Dietary - Purchased Service				0
2.61	5231.1	Dietician - Salary				0
2.62	5233.3	Dietician - Purchased Service				0
2.63	5235.5	Dietary - Supplies and Expenses	16,896			16,896
2.1600	**5200.0**	**Total Dietary**	**480,103**	**0**		**480,103**
		Laundry				
2.64	5310.1	Laundry - Salaries	33,547			33,547
2.65	5320.3	Laundry - Purchased Service				0
2.66	5330.5	Laundry - Supplies and Expenses				0
2.67	5340.5	Laundry - Linen and Bedding				0
2.1700	**5300.0**	**Total Laundry**	**33,547**	**0**		**33,547**
		Housekeeping				
2.68	5410.1	Housekeeping - Salaries	175,570			175,570
2.69	5415.3	Housekeeping -Purchased Service				0
2.70	5420.5	Housekeeping -Supplies and Expenses	37,760			37,760
2.1800	**5400.0**	**Total Housekeeping**	**213,330**	**0**		**213,330**
		Nursing				
		Registered Nurses				
2.71	6030.1	RN Salaries	450,356			450,356
2.72	6035.3	RN Purchased Service	8,744			8,744
2.73	6041.1	LPN Salaries	27,650			27,650
2.74	6042.3	LPN Purchased Service				0
		Nurses Aides				
2.75	6051.1	Nurses Aides Salaries	423,428			423,428
2.76	6052.3	Nurses Aides Purchased Service				0
2.1900	**6000.0**	**Total Nursing**	**910,178**	**0**		**910,178**
		Medical Services				
2.77	6504.1	Quality Assurance Professional				0
2.78	6507.1	Community Support Coordinator				0
		Physicians' Services				
2.79	6514.3	Employee Physicals	383			383
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**	**383**	**0**		**383**
		Medical Supplies & Drugs				
2.81	6520.5	Legend Drugs	165		(165)	0
2.82	6522.5	House Supplies Not Resold	10,212			10,212
2.83	6523.5	Resold to Private Patients			0	0

Table 2A : Detail of Clerical Salaries

Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1	Shannon Howell	Business Manager	A/R, A/P, H/R, Bookkeeper	37,923
2A.2	Patricia Glenzel	Part-Time Receptionist	Concierge-Admin Support	19,690
2A.3	Joanne Gustafson	Part-Time Receptionist	Concierge-Admin Support	22,729
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.100		**Total Clerical Salaries**		**80,342**

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 format)	Amount	Select Code	Brief Description of Service
2B.1	Bernice Lord, CPA	11/8/2023	3,890	F	Progress Billing
2B.2					
2B.3					
2B.4					
2B.5					
2B.100		**Sub-Total**	**3,890**		

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**	**3,890**			

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 :		

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**

2.2100	**6520.0**	**Total Medical Supplies and Drugs**	**10,377**	**0**	**(165)**	**10,212**
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**	**10,760**	**0**	**(165)**	**10,595**
Restorative & Recreational Therapy						
Restorative Therapy						
2.86	7011.1	Indirect Restorative Therapy Salaries				0
2.87	7012.1	Direct Restorative Therapy Salaries			0	0
2.88	7012.2	Direct Restorative Therapy Benefits			0	0
2.89	7013.3	Indirect Restorative Therapy Consultants				0
2.90	7014.3	Direct Restorative Therapy Consultants			0	0
2.2300	**7010.0**	**Total Restorative Therapy**	**0**	**0**	**0**	**0**
Recreational Therapy						
2.91	7021.1	Recreational Therapy - Salaries	56,600			56,600
2.92	7022.3	Recreational Therapy - Purchased Service	3,124			3,124
2.93	7023.5	Recreational Therapy - Supplies and Expenses	5,158			5,158
2.94	7024.8	Recreational Therapy - Transportation			0	0
2.2400	**7020.0**	**Total Recreational Therapy**	**64,882**	**0**	**0**	**64,882**
2.2500	**7000.0**	**Total Restorative & Recreational Therapy**	**64,882**	**0**	**0**	**64,882**
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	0
2.97	8025.5	State & Federal Income Taxes			0	0
2.98	8027.7	Massachusetts Excise Tax			0	0
2.99	8030.0	Refunds and Allowances			0	0
2.101	8040.0	Adult Day Care Costs*			0	0
2.102	8065.0	Other Non-Nursing Costs*	96,226		(96,226)	0
2.2600	**8000.0**	**Total Bad Accts.-Taxes-Refunds-Day Care**	**96,226**		**(96,226)**	**0**
200	**4000.0**	**Total Expenses**	**2,743,400**	**0**	**(142,441)**	**2,600,959**
			A/C # 4000.0	**A/C #9945.0**	**A/C # 9939.0**	

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses

Table 3			1
Line #	Account #	**Description**	**Amount**
3.1	4000.0	Total Reported Operating Expenses	2,743,400
3.2	9945.0	Less: Self-Disallowed Expenses	0
3.3	9939.0	Less: Automatically Disallowed Expenses	(142,441)
3.100	**4001.1**	**Total Non-Allowable Expenses**	**(142,441)**
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	1,387,714
3.9	9302.6	Allocated Direct Variable (Dietician, 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**	**1,387,714**
3.41	NA	Less: Recoverable Income (offsetting operating expenses)	0
300	**4002.0**	**Total Allowable Operating Expenses Claimed**	**3,988,673**

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	2,516,678
4.2	4000.0	Total Cost Report Expenses	2,743,400
4.100		**Net Income (Loss) Cost Report**	**(226,722)**
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	**2516678**
4.6		Variance Between Cost Report and Financial Statements: Expenses	**2743400**
4.7		Variance Between Cost Report and Financial Statements: Net Income	**-226722**
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**	**(226,722)**

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	1,170
1.2	0212.5 & 0212.0	Massachusetts EAEDC	1,620
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	90
100	**0200.0**	**Total Resident Days January 1 - March 31**	**2,880**

Resident Days April 1 - June 30			
Table 2	Account #		1
Line #		**Payer Description**	**Reported Days**
2.1	0310.5 & 0310.0	DTA Days	1,169
2.2	0312.5 & 0312.0	Massachusetts EAEDC	1,621
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	292
200	**0300.0**	**Total Resident Days April 1 - June 30**	**3,082**

Resident Days July 1 - September 30			
Table 3	Account #		1
Line #		**Payer Description**	**Reported Days**
3.1	0410.5 & 0410.0	DTA Days	1,274
3.2	0412.5 & 0412.0	Massachusetts EAEDC	1,851
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	280
300	**0400.0**	**Total Resident Days July 1 - September 30**	**3,405**

Resident Days October 1 - December 31			
Table 4	Account #		1
Line #		**Payer Description**	**Reported Days**
4.1	0510.5 & 0510.0	DTA Days	1,441
4.2	0512.5 & 0512.0	Massachusetts EAEDC	1,748
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	276
400	**0500.0**	**Total Resident Days October 1 - December 31**	**3,465**

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	**5,054**
5.2	0612.5 & 0612.0	Massachusetts EAEDC	**6,840**
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	**938**
500	**0600.0**	**Total Annual Resident Days**	**12,832**

Additional Patient Day Information

Table 6		1	
Line #		**Description**	**Days**
6.1	0140.0	Number of Admissions	7
6.2	0150.0	Number of Discharges	6
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	6,000			6,000					
1.2	Land HCF-2				0					
1.3	Building HCF-4	246,000			246,000		241,900			241,900
1.4	Building HCF-2				0				-	0
1.5	Improvements HCF-4	2,051,943			2,051,943	5.00%	974,078			974,078
1.6	Improvements HCF-2				0	5.00%			-	0
1.7	Equipment HCF-4	231,170			231,170	10.00%	171,736			171,736
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			0	33.33%			-	0
100	**Total Claimed Fixed Asset Depreciation Expense**	**2,535,113**	**0**	**0**	**2,535,113**		**1,387,714**	**0**	**0**	**1,387,714**

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 - Real Property	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		-	0
2.3	Building Insurance	0	-	0
2.4	Real Estate Taxes		-	0
2.5	Personal Property Taxes		-	0
2.6	Other Claimed Fixed Assets**		-	0
200	**Total Claimed Fixed Asset Other Expenses**	**0**	**0**	**0**

Total Claimed Fixed Asset Expenses

Table 3		1	
Line #	Description	Total	
300	**Total Fixed Assets Expenses Claimed**	**1,387,714**	**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)	1884
4.3	during the reporting period?	No
4.4	owns the real assets of the facility (realty company)	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	Owners (e.g. related parties)				
5.2	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	project the reasonably anticipated costs and		Refer to Regulation 101 CMR 304.06(1)(g)	
6.2	became operational during the year? If so, does this		Refer to Regulation 101 CMR 304.06(1)(g)	
6.3	facility or major additions became operational.		Refer to Regulation 101 CMR 304.06(1)(g)	
6.4	administrative adjustment for substantial capital		Refer to Regulation 101 CMR 304.06(1)(g)	
6.5	petition. (MM/DD/YYYY)		Refer to Regulation 101 CMR 304.06(2)(c)	
6.6	a Determination of Need (DON) approval by the		Refer to Regulation 101 CMR 304.06(2)(c).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 (MCE) total DON?			
7.5	Has this facility received a letter from the DPH Office of Determination of Need and Compliance?			
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							-		
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	00,000.0						
		7110.2	7210.2	7310.2	4306.1	7410.2	7510.2	7610.2
1.2	Maintenance Staff	00,001.3	1.0	2638.0	78,999	7,308		-
		7111.2	7211.2	7311.2	5105.1	7411.2	7511.2	7611.2
1.3	Dietary Staff	00,009.3	14.0	19304.0	255,893	2,088		89
		7112.2	7212.2	7312.2	5205.1	7412.2	7512.2	7612.2
1.4	Dietician	00,001.3	1.0	2640.0	95,232	609		31
		7113.2	7213.2	7313.2	5231.1	7413.2	7513.2	7613.2
1.5	Laundry Staff	00,001.2	1.0	2471.0	33,547	692		31
		7114.2	7214.2	7314.2	5310.1	7414.2	7514.2	7614.2
1.6	Housekeeping Staff	00,005.4	5.0	11231.0	175,570	2,799		131
		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	00,000.0						
		7119.2	7219.2	7319.2	6507.1	7419.2	7519.2	7619.2
1.9	Social Services Staff	00,000.0						
		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	00,001.2	1.0	2557.0	56,600	-		-
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,001.2	1.0	2536.0	89,793	7,308		218
		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	00,005.2	3.0	10797.0	80,342			-
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	00,005.6	12.0	11732.0	450,356	2,171		150
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	00,000.9	1.0	1834.0	27,650	740		29
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,009.6	15.0	20049.0	423,428	2,911		91
		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	
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.	

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	Lathrop Home	
1.2	Preparer's Last Name	Howell	
1.3	Preparer's First Name	Shannon	
1.4	Preparer's Middle Name		
1.5	Title	Business Director	
1.6	Street Address	215 South Street	
1.7	City	Northampton	
1.8	State	MA	
1.9	Zip Code	01060	
1.10	Phone Number	413-584-2865	
1.11	Email Address	shannon@lathrophome.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.**		**X**
1.13	Date of Authorization:	4/30/2024	

Certification by Owner, Partner, or Officer

Table 2		1	
2.1	Last Name	Carroll	
2.2	First Name	Tracy	
2.3	Middle Name		
2.4	Title	Executive Director	
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.**	**X**
2.6	Date of Authorization:	4/30/2024	

The HCF-2 RH must be completed when expenses are included i
residential care facility. The HCF-2 RH serves the dual purpose o

Part I: Facility Specific Realty Company

Facility Information

Table 1	
Line #	**Description**
1.1	Realty Company Name
1.2	FEIN
1.3	Realty Company ORGID #
1.4	Balance Sheet Date
1.5	Realty Company Address
1.6	City
1.7	Zip
1.8	Telephone

IMPORTANT: Tables 2 through 6 are an integral part of the
defined as a person or entity having any rights or benefits o
of ownership, either direct or indirect, through one or more
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 mor
"Owner Name".

Table 2	1
Line #	**Owner Name (Last, First)**
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 fac

Table 3	1
Line #	**Nursing and/or Rest Home**
3.1	
3.2	
3.3	
3.4	
3.5	

Indebtedness

List any indebtedness (mortgages, deeds, trust instruments, not

Table 4	1
Line #	**Select type of debt**
4.1	
4.2	
4.3	
4.4	
4.5	

Related Party Transactions

Indicate any entity, person, or related party as defined in 101 CI reporting year. (Attach an addendum if necessary.)

Table 5	1
Line #	**Entity/Person**
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 additional space is needed, use the Footnotes and Explanations

Table 6	1
Line #	**Select Owner, Partner, Officer**
6.1	
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

Table 7	1
Line #	**Name**
7.1	
7.2	
7.3	
7.4	
7.5	

Part II: Condensed Facility Specific Rea

NOTE: Reported amount should be the amount reported on the

Table 1	***Income***
Line #	**Account #**
1.1	3510.0
1.2	3520.0
1.3	3530.0
1.4	3540.0
100	**3500.0**
Table 2	***Expenses***
Line #	**Account #**
2.1	9540.0
2.2	9540.5
2.3	9545.0
2.4	9545.5
2.5	9546.0
2.6	9547.0
2.7	9550.0
2.8	9560.8
2.9	9570.0
2.10	9575.0
2.11	9580.0
2.12	9590.0
200	**9500.0**
Table 3	***Assets***
Line #	**Account #**
3.1	1020.0
3.2	1030.0
3.3	1040.0
3.4	1160.0
3.5	1170.0
3.6	1180.0
3.7	1185.0
3.8	1270.0
3.9	1280.0
3.10	1300.0
3.11	1310.0
3.12	1510.0
3.13	1521.1
3.14	1522.2

3.15	1611.1
3.16	1612.2
3.17	1631.1
3.18	1632.2
3.19	1651.1
3.20	1652.2
3.21	1701.1
3.22	1702.2
3.23	1710.1
3.24	1710.2
3.25	1980.0
3.26	1979.0
3.27	1975.1
3.28	1975.2
300	**1000.0**
Table 4	***Liabilities***
Line #	**Account #**
4.1	2110.0
4.2	2120.0
4.3	2130.0
4.4	2150.0
4.5	2160.0
4.6	2240.0
4.7	2295.0
4.8	2310.0
4.9	2320.0
400	
Table 5	***Net Worth***
Line #	**Account #**
5.1	2520.0
5.2	2530.0
5.3	2540.0
5.4	2545.0
5.5	2550.0
5.6	2620.0
5.7	2630.0
5.8	2640.0
5.9	2650.0
500	
600	

Part III: Facility Specific Realty Compar

Claimed Fixed Asset Depreciation Expenses

Note: This table does not include all fixed assets for the realty compan assets of other nursing, non-nursing or residential care programs, such schedule.

Table 1	
Line #	**Description**
1.1	Land HCF-2
1.2	Building HCF-2
1.3	Improvements HCF-2
1.4	Equipment HCF-2
1.5	Software/Limited Life Assets HCF-2
100	**Total Claimed Fixed Asset Depreciation Expense**

Claimed Other Fixed Asset Expenses

Table 2	
Line #	**Description**
2.1	Long-Term Interest Claimed *
2.2	Portion
2.3	Building Insurance
2.4	Real Estate Taxes
2.5	Personal Property Taxes
2.6	Other **
2.7	Other Recoverable Fixed Asset Income
200	**Total Claimed Fixed Asset Other Expenses**

Total Claimed Fixed Asset Expenses

Table 3	
Line #	**Description**
300	**Total Claimed Fixed Asset Expenses**

Detail of Other Operating Expenses A/C # 95

Table 4	
Line #	**Describe Expense**
4.1	License & Permits
4.2	Management Fee
4.3	Auto expense
4.4	
4.5	

400	Total Other Operating Expenses

Part IV: Facility Specific Realty Compar

SCHEDULE : Mortgages & Notes

IMPORTANT NOTE: Report all mortgages and notes payable wh
Financial Information above.

Mortgages and Notes Supporting Fixed Assets

Table 1	1
Line #	**Select Type of Notes Payable**
1.1	
1.2	
1.3	
1.4	
1.5	
1.6	
1.7	
1.8	
100	**TOTALS**

Working Capital Debt

Table 2	1
Line #	**Lender Name**
2.1	
2.2	
2.3	
2.4	
2.5	
2.6	
200	**TOTALS**

RESIDENTIAL CARE FACILIT

SCHEDULE : Condensed Realt

n the HCF-4 Profit or Loss Schedule account # 4535.8 "Rent Expenses for Real Propert
f being a report to the Center by the individual or business entity which owns the rea

Information and Disclosures

1

HCF-4 cost report. These tables must be completed in its entirety. When compl
f ownership and having ***an interest of record*** in ay partnership, joint venture, c
intermediaries, through any understanding or relationship with a person or en

e in this realty company. If the realty company is owned by a corporation, chain, or tr

2	3
Address	**Percent Ownership**

ilities in which the owners listed in Table 2 own, directly or indirectly, an interest of 5

2	3
VPN	**Name of Owner**

:es, or other financial information) of (1) the realty company to the direct or indirect c

2	3
Select Payable From	**Original Debt Amount**

MR 204.00 and that (a) provides services, facilities, goods and/or supplies to this realt

2	3
Goods/Services	**Billing/Compensation**

f the business and to disclose the salary and other compensation paid to owners as w
Tab.

2	3
Owner Name	**Owner Title**

› have the highest compensation being claimed on this report.

	2
Title	**% Time Devoted - Administrative**

ity Company Financial Information

facility specific realty company financial statements.

Description	Reported Amount
Residential Care Facility Rental Income	
Other Rental Income	
Other Income	
Recoverable Fixed Asset Income	
Total Income Reported	**0**

Description	Reported Amount
Real Estate Taxes	
Personal Property Taxes	
Long Term Interest (Mortgages & Notes schedule)	0
Working Capital Interest (Mortgages & Notes schedule)	0
Interest on Late Payments, Penalties	
Other Expenses **	
Depreciation: Building	
Depreciation: Improvements	
Depreciation: Equipment	
Depreciation: Software/Limited Life Assets	
Insurance: Building, Building Improvements, Equipment	
Other Operating Expenses	
Total Expenses Reported	**0**

Description	Reported Amount
Cash - Checking Account	
Cash - On hand	
Cash - Other	
Loans Receivable - Due from Officers/Owners	
Loans Receivable - Due from Employees	
Loans Receivable - Due from Subsidiaries/Affiliates	
Other Loans Receivable	
Prepaid Interest	
Prepaid Insurance	
Other Prepaid Expenses	
Other Current Assets	
Land – Cost	
Building – Cost	
Building – Accumulated Depreciation	

Building Improvements – Cost	
Building Improvements – Accumulated Depreciation	
Other Improvements – Cost	
Other Improvements – Accumulated Depreciation	
Equipment – Cost	
Equipment – Accumulated Depreciation	
Motor Vehicles – Cost	
Motor Vehicles – Accumulated Depreciation	
Software/Limited Life Assets - Cost	
Software/Limited Life Assets – Accumulated Depreciation	
Other Deferred Charges and Other Non-Current Assets	
Construction in Progress	
Mortgage Acquisition Cost	
Accumulated Amortization of Mortgage Acquisition Cost	
Total Assets	**0**

Description	**Reported Amount**
Notes/Loans Payable to Officer, Owner, Related Parties	
Notes/Loans Payable to Subsidiaries and Affiliates	
Notes/Loans Payable to Banks	
Other Short-Term Financing	
Long-Term Debt, Current Portion *	
Accrued Taxes – Realty and Management	
Other Current Liabilities	
Mortgages *	
Other Long-Term Debt *	
Total Liabilities	**0**

Description	**Reported Amount**
Proprietorship or Partnership Capital	
Proprietor Drawings	
Partnership/Member (LLC) Drawings	
Contributions	
Net Profit/(Loss) Year to Date	
Capital Stock	
Additional Paid in Capital	
Treasury Stock	
Retained Earnings	
Total Net Worth	**0**
Total Liabilities and Net Worth	**0**

ıy Claimed Fixed Asset Expenses

ıy; only those that can be claimed as residential care facility fixed assets. Allowable basis is the
ı as an adult day care program, the related fixed asset expenses must be reported as disallowe

1	2
Allowable Cost Basis Beginning Balance	Claimed Additions
0	

1
Claimed Fixed Asset Expenses - Realty Company (HCF-2 RH)
0

1	
Amount	
0	A/C # 9502.1

502.2

1	2
Reported Expense	Amount Self Disallowed

0	0
A/C # 9590.0	

ıy Mortgages and Notes Payable

ether or not interest expense is incurred on this schedule. Each new note should be re

2	3
Lender Name	Related Party (Select Yes/No)

2	3
Related Party (Select Yes/No)	Beginning Balance: Jan 1

Y FY2023 COST REPORT (HCF-4)

y Company Cost Report (HCF-2 RH)

y". This schedule must be completed whenever rent is paid to an individual, partnership, realty tru
l property to accurately reflect the complete financial condition AND a claim for reimbursement.

leting these tables the following definitions of direct and indirect beneficial owner apply: 1) A
orporation or other entity; and 2) An **indirect beneficial owner** is defined as a person having
tity, ***resulting in benefits of ownership which are not of record*** . It is incumbent upon the ow

ust, list the name of the corporation, chain, or beneficial owner under

4	5
Select Ownership Type	**Direct or Indirect?**

5% or more.

4	5
Company Address	**% Ownership**

owners listed in Table 2 or (2) the direct or indirect owners listed in Table 2 to the realty company.

4	5	6
Date Issued	**Balance 12/31**	**Select Payable To**

ty company; or (b) receives any salary, fee, or other compensation from this realty company. Indica

4	5	6
Mark up	**Cost**	**Account Posted**
	-	
	-	
	-	
	-	
	-	
	-	

ell as what accounts were charged. Sole proprietors should report the same amount as reported in

4	5	6
% Time Devoted	**Salary**	**Employee Benefits**

3	4	5
% Time Devoted- Plant Operation, Maintenance, and Security	% Time Devoted - Medical Services	% Time Devoted - Other

Explanation

Explain:

Explain:

Explain:
Explain:

Assets Equals Liabilities and Net Worth

e portion of fixed assets used for the care of publicly-aided residents. Claimed deletions include retired, sold,
ed on this schedule in column 7 "Non-Allowable Depreciation Expense". The allocation methodology for alloc

3	4	5
Claimed Deletions	Allowable Cost Basis Ending Balance	Depreciation %
	0	
	0	
	0	5.00%
	0	10.00%
	0	33.33%
0	0	

3
Claimed Amount
0
0
0
0
0

0	A/C # 9502.2

eported with all data fields completely filled in. New mortgages or enhancements of existing mortg

4	5	6
Date Mortgage Acquired	Due Date	Number of Months Amortized

4	5	6
New Loan Amount	Start Date	Principal Payment

st or other entity whether affiliated or not with the

A **direct owner** is
g any benefits or rights
vner to fully disclose

7
List Owners Name

ate the amount paid by this realty company for this

7	8
Name of Owner	**% Ownership**

the draw account and under no circumstances should any amount be claimed for personal ser

7	8	9	10
Payroll Taxes	**Workers' Comp.**	**Gr. Life/Health Ins.**	**Draw**

6	7	8	9
Total Time (Must equal 100%)	**Salary**	**Employee Benefits**	**Payroll Taxes**
0.00%			
0.00%			
0.00%			
0.00%			
0.00%			

written-off, damaged, and fully depreciated assets. If the realty company owns fixed
ating fixed asset expenses must be reported in the Footnotes and Explanations

6	7	8
Depreciation Expense Reported on Financial	Non-Allowable Depreciation Expense or Add-Backs	Claimed HCF-2 RH Depreciation
0		**0**
0		**0**
0		**0**
0		**0**
0	**0**	**0**

;ages must be reported on a separate line. Total Mortgages and Notes as od December 31 and

7	8	9	10
Monthly Payments	**Original Loan Amount**	**Mortgage Acquisition Costs**	**Amortization of Mortgage**
		0	**0**

7	8	9
Ending Balance: Dec 31	**Interest Rate %**	**Interest Expense**
0		
0		
0		
0		
0		
0		
-		**0**

2110.0, 2120.0, 2130.0, and **Equals A/C# 9545.5**

vices in an account other than draw. If

11	12
Other	**Total**
	-
	-
	-
	-
	-
	-
	-

	-

10	11	12	13	14
Workers' Comp.	**Gr. Life/Health Ins.**	**Draw**	**Other**	**Total**
				-
				-
				-
				-
				-

Total Expenses must match amounts reported in Part II

11	12	13	14	15
Beginning Loan Balance: Jan 1	Beginning Balance - New Loans	Principal Payments	**Pay Off Amount**	**Pay Off Date**

16	17	18	19	20
Ending Loan Balance: Dec 31	Interest Rate %	Interest Expense (B)	Period Expenses (C)	Total Fixed Interest (Amortization Interest
0				0
0				0
0				0
0				0
0				0
0				0
0				0
0				0
0		0	0	0

Equals Sum of A/C #s 2160.0, 2310.0, and 2320.0

Equals A/C # 9545.0