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	5500923
1.2	Provider ID/MMIS ID	110062864/A
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2023
1.4	Name of Facility	MOUNT PLEASANT HOME
1.5	Street Address	301 S HUNTINGTON AVE
1.6	City	JAMAICA PLAIN
1.7	Zip	02130
1.8	Telephone	617-522-7600
1.9	Federal Employer Identification Number	04-2103822
1.10	Responsible Person's Name	KATHLEEN SEAMAN
1.11	Responsible Person's Email	seaman@mountpleasanthome.org
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	EXECUTIVE DIRECTOR
1.13	List Name of Person to Receive Rate Notifications	KATHLEEN SEAMAN
1.14	List Email of Person to Receive Rate Notifications	seaman@mountpleasanthome.org
1.15	Status (Select Profit/Non-Profit from Dropdown Menu)	Non-Profit
1.16	Legal Status (Select from Dropdown Menu)	3. MA Corp-Chapter 180
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.	60
1.19	Enter the facility's constructed bed capacity.	60
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)	8/11/1925
1.22	Has the facility had a change in long-term financing during this cost report year?	No
1.23	Is the facility managed by a management company?	No
1.24	If line 1.23 is Yes, list the COMB# of the management company as reported on the management company cost report.	
1.25	If line 1.23 is Yes, list the name of the management company as reported on the management company cost report.	
1.26	Are you completing the HCF-2 RH (Realty Company Report) Tab in this Excel Workbook?	No
1.27	List realty company name(s) as reported on each realty company cost report.	
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.	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 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	1/1/2023	12/31/2023	60
1B.2			
1B.3			

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : GENERAL INFORMATION

Contact Information

Table 2		1
Line #	Description	
2.1	Contact Person Name	KATHLEEN SEAMAN
2.2	Residential Care Facility or Firm Name	MOUNT PLEASANT HOME
2.3	Title	EXECUTIVE DIRECTOR
2.4	Street Address	301 S HUNTINGTON AVE
2.5	City	JAMAICA PLAIN
2.6	State	MA
2.7	Zip Code	02130
2.8	Phone Number	617-522-7600
2.9	Email Address	seaman@mountpleasanthome.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	RAYMOND WHITLOW
3.3	Preparer's Affiliation	CONTRACTED PREPARER
3.4	Nursing Facility or Firm Name	HANSEN HUNTER LLC
3.5	Title	REIMBURSEMENT DIRECTOR
3.6	Street Address	7080 SW FIR LOOP STE 100
3.7	City	PORTLAND
3.8	State	OR
3.9	Zip Code	97223
3.10	Phone Number	971-201-7802
3.11	Email Address	RWHITLOW@HHC-CPA.COM
3.12	Type of Accounting Service Performed	Other

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	MOUNT PLEASANT HOME, INC	301 S HUNTINGTON AVE	100.0%	Corporation	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	NONE				
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					-			
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	ANN MASTERSON	PRESIDENT	5.00%	-							-
5.2	Officer	ALVIN SHIGGS	VP	5.00%	-							-
5.3	Officer	GREG BATSEVITSKY	TREASURER	5.00%	-							-
5.4	Officer	NINA LEV	SECRETARY	5.00%	-							-
5.5	Officer	SUSAN M MCDERMETT	TRUSTEE	5.00%	-							-
5.6	Officer	KAREN RIDGLEY	TRUSTEE	5.00%	-							-
5.7	Officer	CANDACE CHANG	TRUSTEE	5.00%	-							-
5.8	Officer	PRISCILLA ELLIS	TRUSTEE	5.00%	-							-

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	KATHLEEN SEAMAN	EXECUTIVE DIRECTOR	100.00%				**100.00%**	196,116	2,213	14,119	136	11,710	-	-	**224,294**
6.2	TANYA LIVINGSTON	DIR OF ADM FINANCE	100.00%				**100.00%**	143,587	2,213	12,327	99	11,516	-	-	**169,742**
6.3	JONAH WEINHARDT	MAINTENANCE		100.00%			**100.00%**	92,121	2,213	8,390	1,398	19,520	-	-	**123,642**
6.4	WILLIAM SMALLEY	DIR OF RES SERVICES				100.00%	**100.00%**	94,143	2,213	8,544	65	19,507	-	-	**124,472**
6.5	CARMEN WORNUM	NURSING			100.00%		**100.00%**	88,931	2,213	8,146	1,759	11,710	-	-	**112,759**

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	1,495,810
1.2	1030.0	Cash - On Hand	4,867
1.3	1040.0	Temporary Investments	0
1.4	1050.0	Other Cash	788,074
1.100	**1010.0**	**Total Cash and Cash Equivalents**	**2,288,751**
		Accounts Receivable	
1.5	1080.0	Private Patients	163,959
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	321,054
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**	**485,013**
		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	38,756
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**	**38,756**
1.21	1310.0	Other Current Assets	145,880.00
100	**1005.0**	**Total Current Assets**	**2,958,400**

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	683,601		**683,601**
2.2	1520.0	Building	18,295,940	(5,820,585.00)	**12,475,355**
2.3	1610.0	Building Improvements	479,970	(186,072.00)	**293,898**
2.4	1625.0	Leasehold Improvements	-	-	**0**
2.5	1630.0	Other Improvements	-	-	**0**
2.6	1650.0	Equipment	582,212	(529,580.00)	**52,632**
2.7	1700.0	Motor Vehicles	114,887	(35,622.00)	**79,265**
2.8	1710.0	Software/Limited Life Assets	-	-	**0**
200	**1500.0**	**Total Non-Current Fixed Assets**			**13,584,751**

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : BALANCE SHEET

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 *	117,058
3.7	1975.2	Accumulated Amortization of Mortgage Acquisition Costs	(72,202)
3.8	1975.0	Unamortized Mortgage Acquisition Costs	**44,856**
3.9	1979.0	Construction in Progress *	23,101
3.10	1980.0	Other **	1,425,327
3.100	**1900.0**	**Total Deferred Charges and Other Assets**	**1,493,284**
300	**1000.0**	**Total Assets**	**18,036,435**

Current Liabilities			
Table 4			1
Line #	Account #	**Description**	**Account Balance**
		Accounts Payable	
4.1	2020.0	Trade Payables	11,045
4.2	2030.0	Accrued Expenses	55,107
4.3	2047.0	Due to Commonwealth of MA	-
4.100	**2010.0**	**Total Accounts Payable**	**66,152**
4.4	2050.0	Patient Funds Due	53,330
		Notes and Loans Payable (See Mortgages & Notes Schedule)	
4.5	2110.0	Officer, Owner, or Related Parties	-
4.6	2120.0	Subsidiaries and Affiliates	-
4.7	2130.0	Banks	-
4.8	2140.0	Motor Vehicles	-
4.9	2150.0	Other Short-Term Financing	-
4.10	2160.0	Payment Due Within One Year on Long-Term Debt *	-
4.200	**2100.0**	**Total Notes and Loans Payable**	**-**
		Accrued Salaries and Payroll Liabilities	
4.11	2190.0	Accrued Salaries	162,353
4.12	2200.0	Accrued Payroll Tax Withheld	-
4.13	2210.0	Accrued Employee Taxes Payable	-
4.14	2220.0	Other Payroll Liabilities	(1,494)
4.300	**2180.0**	**Total Accrued Salaries and Payroll Liabilities**	**160,859**
		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	3,334
4.400	**2250.0**	**Total Other Current Liabilities**	**3,334**
400	**2005.0**	**Total Current Liabilities**	**283,675**

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : BALANCE SHEET

Long-Term Liabilities			
Table 5			1
Line #	Account #	**Description**	**Account Balance**
		Long-Term Liabilities (See Mortgages & Notes Schedule)	
5.1	2310.0	Mortgages *	8,749,248.00
5.2	2320.0	Other Long Term Debt *	-
5.100	**2300.0**	**Total Long-Term Liabilities**	**8,749,248**
500	**N/A**	**Total Liabilities**	**9,032,923**

Net Worth			
Table 6			1
Line #	Account #	**Description**	**Account Balance**
		Proprietorship or Partnership Capital	
6.1	2520.0	Capital	0
6.2	2530.0	Proprietor Drawings	0
6.3	2540.0	Partner Drawings	0
6.4	2550.0	Net Profit(Loss) - Current Year	0
6.100	**2510.0**	**Total Proprietorship or Partnership Capital**	**0**
6.5	2620.0	Capital Stock	0
6.6	2630.0	Additional Paid in Capital	0
6.7	2640.0	Treasury Stock	0
6.8	2650.0	Retained Earnings	9,003,512
6.200	**2610.0**	**Total Corporation Capital**	**9,003,512**
600	**2000.0**	**Total Liabilities and Net Worth**	**18,036,435**

Balance Sheet Check			
Table 7			1
Line #	Account #	**Description**	**Account Balance**
7.1	**1000.0**	**Total Assets**	18,036,435
7.2	**2000.0**	**Total Liabilities and Net Worth**	18,036,435
		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	398,522
1.2	3022.5	DTA	0
1.3	3022.6	MA DTA Patient Resource Income	1,200,310
1.4	3022.7	Non-MA DTA	2,793,144
1.5	3023.1	MA Commission for the Blind	0
1.6	3023.2	VA and Other Public	0
1.7	3025.3	Adult Day Care Income	0
1.8	3026.2	Other Non-Nursing Income	0
1.9		COVID-Related Supplemental Payments	0
Ancillary Services (Use Table 1A to Right to Itemize Expenses)			
1.10	3031.1	Private	0
1.11	3032.5	Medicaid (DMA)	0
1.12	3032.7	Non-MA Medicaid	0
1.13	3033.1	MA Commission for the Blind	0
1.14	3033.2	VA & Other Public	0
1.100	**3030.0**	**Total Ancillary Services**	**0**
Miscellaneous and Recoverable Income			
1.15	3120.0	Endowment & Other Nonrecoverable **	257,159
1.16	3140.0	Laundry Recoverable Income	0
1.17	3150.0	Vending Machines Recoverable Income	0
1.18	3160.0	Bad Debt Recovery	0
1.19	3170.0	Prior Year Retroactive Adjustment	0
1.20	3180.0	Interest Income	5,202
1.21	3194.0	Operating Costs Recoverable	0
1.22	3196.0	Fixed Costs Recoverable	906,735
1.200	**3130.0**	**Total Miscellaneous and Recoverable Income**	**1,169,096**
100	**3000.0**	**Total Gross Income**	**5,561,072**

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 Expenses	Self Disallowed Expenses (9945.0)	Automatically Disallowed Expenses (9939.0)	Total Allowable Expenses
Administrative Expenses						
2.1	4110.1	Administrative/Responsible Person Salaries	156,130			156,130
2.2	4125.1	Officer Salaries*	0		0	0
Other Expenses						
2.3	4140.1	Clerical Salaries (Use Table 2A to Right to Itemize Salaries)	181,662			181,662
2.4	4150.3	Electronic Data Processing, Payroll, and Bookkeeping Services	69,261			69,261
2.5	4160.3	Management Fees	0		0	0
2.6	4160.6	Management Consultants*	0		0	0
2.100	**4130.1**	**Total Other Expenses**	**250,923**	**0**	**0**	**250,923**
2.200	**4100.0**	**Total Administrative Expenses**	**407,053**	**0**	**0**	**407,053**
General Supplies & Expenses						
2.7	4250.5	Office Supplies	41,040			41,040
2.8	4261.5	Phone	13,990			13,990
2.90	4262.6	Directory Advertising	0		0	0
2.300	**4260.0**	**Total Telephone Expenses**	**13,990**	**0**	**0**	**13,990**
Travel Expenses						
2.10	4275.5	Motor Vehicle Expense*	2,290			2,290
2.11	4280.5	Conventions and Meetings	14,875			14,875
2.400	**4270.5**	**Total Travel Expenses**	**17,165**	**0**		**17,165**
Advertising Expenses						
2.12	4295.7	Help Wanted	1,460			1,460
2.13	4298.7	Promotional	8,663		(8,663)	0
2.500	**4290.0**	**Total Advertising Expenses**	**10,123**	**0**	**(8,663)**	**1,460**
Licenses and Dues Expenses						
2.14	4301.7	Licenses and Dues: Patient Care Related Portion	57,953			57,953
2.15	4302.3	Licenses and Dues: Not Related to Patient Care	0		0	0
2.600	**4300.0**	**Total Licenses and Dues Expenses**	**57,953**	**0**	**0**	**57,953**
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	1,799			1,799
2.19	4306.4	Job Related Education	0			0
2.700	**4305.0**	**Total Education and Training Expenses**	**1,799**	**0**		**1,799**
Employee Benefits						
2.20	4310.1	Employee Benefits - Pensions **	0			0
2.21	4310.2	Employee Benefits - Other	79,658			79,658
2.22	4339.2	Officer Profit Sharing and Other Benefits	0		0	0
2.800	**4310.0**	**Total Employee Benefits**	**79,658**	**0**	**0**	**79,658**
Accounting Expenses						
2.23	4350.3	Accounting: Appeal Services	0		0	0
2.24	4360.3	Accounting: Other (Use Table 2B to Right to Itemize Expenses)	22,395			22,395
2.900	**4340.0**	**Total Accounting Expenses**	**22,395**	**0**	**0**	**22,395**
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	199,301			199,301
2.29	4411.2	Payroll Taxes - Officers	0		0	0
2.1100	**4400.0**	**Total Payroll Taxes**	**199,301**	**0**	**0**	**199,301**
Insurance Expense						
2.30	4428.7	Insurance: Department of Unemployment Assistance Claims (DUA) - A&G Portion	2,869			2,869
2.31	4431.7	Insurance: Malpractice and General Liability *	79,168			79,168
2.32	4432.7	Key Person Insurance	0		0	0
2.33	4590.8	Insurance: Building Improvements and Equipment	0		0	0
2.34	4424.1	Workers' Comp - Other	23,801			23,801
2.35	4424.2	Workers' Comp - Officers	0		0	0
2.36	4426.1	Group Life/Health - Other	206,991			206,991
2.37	4426.2	Group Life/Health - Officers	0		0	0
2.1200	**4420.0**	**Total Insurance Expenses**	**312,829**	**0**	**0**	**312,829**
2.38	4415.0	Interest on Late Payments, Penalties	0		0	0
2.39	4430.0	Interest on Working Capital	-		0	0
2.40	4435.0	Pre-Opening Expenses	0		0	0
2.41	4443.00	Other Operating Expenses (Use Table 2C to Right to Itemize Expenses)	11,056			11,056
2.1300	**4200.0**	**Total General Supplies and Expenses**	**767,309**	**0**	**(8,663)**	**758,646**

Table 2A : Detail of Clerical Salaries

Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1	LIVINGSTON, TANYA	DIR ADM & FIN	A/R, A/P AND PAYROLL	143,245
2A.2	WEINHARDT, SHEYLA C	ACCOUNTING ASSISTANT	A/R, A/P AND PAYROLL	38,417
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.100		**Total Clerical Salaries**		**181,662**

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

Table 2B : Detail of Other Accounting Expenses

Part 1: Purchased Service Accounting Expenses

Line #	Vendor Name	Date Occurred (MM/DD/YYYY)	Amount	Select Code	Brief Description of Service
2B.1	PETER B. PLUMB, CPA	12/31/2023	21,395	F	AUDIT
2B.2	EF ASSOCIATES LLC	12/31/2023	1,000	A	PREPARATION OF HCF REPORTS
2B.3					
2B.4					
2B.5					
2B.100		**Sub-Total**	**22,395**		

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**	**22,395**			

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 :	

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : Profit Loss Statement

2.42	4510.8	Real Estate Taxes	0		0	0
2.43	4515.8	Personal Property Taxes*	0		0	0
2.44	4520.8	Interest Long-Term (See Mortgages & Notes Schedule)	196,415		(196,415)	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	0
2.48	4565.8	Depreciation - Building Improvements	549,153		(549,153)	0
2.49	4567.8	Depreciation - Leasehold Improvements	0		0	0
2.50	4568.8	Depreciation - Other Improvements	0		0	0
2.51	4570.8	Depreciation - Equipment	0		0	0
2.52	4585.8	Depreciation - Software/Limited Life Assets	0		0	0
2.1400	**4540.0**	**Total Fixed Costs**	**745,568**		**(745,568)**	**0**
Plant Operation, Maintenance & Security						
2.53	5105.1	Plant Operations, Maintenance & Security - Salaries	275,088			275,088
2.54	5110.3	Plant Operations, Maintenance & Security - Purchased Service	204,516			204,516
2.55	5115.5	Plant Operations, Maintenance & Security - Supplies and Expenses	5,356			5,356
2.56	5120.5	Plant Operations, Maintenance & Security - Utilities	224,215			224,215
2.57	5130.7	Plant Operations, Maintenance & Security - Repairs	42,124			42,124
2.1500	**5100.0**	**Total Plant Operation, Maintenance & Security**	**751,299**	**0**		**751,299**
Dietary						
2.58	5205.1	Dietary - Salaries	0			0
2.59	5220.5	Dietary - Food	0			0
2.60	5221.3	Dietary - Purchased Service	737,129			737,129
2.61	5231.1	Dietician - Salary	0			0
2.62	5233.3	Dietician - Purchased Service	0			0
2.63	5235.5	Dietary - Supplies and Expenses	12,803			12,803
2.1600	**5200.0**	**Total Dietary**	**749,932**	**0**		**749,932**
Laundry						
2.64	5310.1	Laundry - Salaries	12,694			12,694
2.65	5320.3	Laundry - Purchased Service	0			0
2.66	5330.5	Laundry - Supplies and Expenses	18,734			18,734
2.67	5340.5	Laundry - Linen and Bedding	0			0
2.1700	**5300.0**	**Total Laundry**	**31,428**	**0**		**31,428**
Housekeeping						
2.68	5410.1	Housekeeping - Salaries	186,927			186,927
2.69	5415.3	Housekeeping -Purchased Service	3,945			3,945
2.70	5420.5	Housekeeping -Supplies and Expenses	55,727			55,727
2.1800	**5400.0**	**Total Housekeeping**	**246,599**	**0**		**246,599**
Nursing						
Registered Nurses						
2.71	6030.1	RN Salaries	101,789			101,789
2.72	6035.3	RN Purchased Service	0			0
2.73	6041.1	LPN Salaries	0			0
2.74	6042.3	LPN Purchased Service	0			0
Nurses Aides						
2.75	6051.1	Nurses Aides Salaries	601,264			601,264
2.76	6052.3	Nurses Aides Purchased Service	2,753			2,753
2.1900	**6000.0**	**Total Nursing**	**705,806**	**0**		**705,806**
Medical Services						
2.77	6504.1	Quality Assurance Professional	0			0
2.78	6507.1	Community Support Coordinator	0			0
Physicians' Services						
2.79	6514.3	Employee Physicals	0			0
2.80	6515.3	Other Medical Services Expenses (Use Table 2E to Right to Itemize Expenses)	0			0
2.2000	**6510.0**	**Total Physicians' Services**	**0**	**0**		**0**
Medical Supplies & Drugs						
2.81	6520.5	Legend Drugs	0		0	0
2.82	6522.5	House Supplies Not Resold	6,168			6,168
2.83	6523.5	Resold to Private Patients	0		0	0
2.2100	**6520.0**	**Total Medical Supplies and Drugs**	**6,168**	**0**	**0**	**6,168**
2.84	6530.0	Pharmacy Consultant	0			0
2.85	6540.0	Social Service Worker (Including Behavioral Health)	25,847			25,847
2.2200	**6500.0**	**Total Medical Services**	**32,015**	**0**	**0**	**32,015**
Restorative & Recreational Therapy						
Restorative Therapy						
2.86	7011.1	Indirect Restorative Therapy Salaries	0			0
2.87	7012.1	Direct Restorative Therapy Salaries	0		0	0
2.88	7012.2	Direct Restorative Therapy Benefits	0		0	0
2.89	7013.3	Indirect Restorative Therapy Consultants	0			0
2.90	7014.3	Direct Restorative Therapy Consultants	0		0	0
2.2300	**7010.0**	**Total Restorative Therapy**	**0**	**0**	**0**	**0**
Recreational Therapy						
2.91	7021.1	Recreational Therapy - Salaries	351,103			351,103
2.92	7022.3	Recreational Therapy - Purchased Service	36,169			36,169
2.93	7023.5	Recreational Therapy - Supplies and Expenses	83,085			83,085
2.94	7024.8	Recreational Therapy - Transportation	0		0	0
2.2400	**7020.0**	**Total Recreational Therapy**	**470,357**	**0**	**0**	**470,357**
2.2500	**7000.0**	**Total Restorative & Recreational Therapy**	**470,357**	**0**	**0**	**470,357**
Bad Accts.-Taxes-Refunds-Day Care						
2.95	8010.0	Bad Accounts - Refunds, Taxes, Day Care	0		0	0
2.96	8015.0	Fines, Late Charges, and Penalties	0		0	0
2.97	8025.5	State & Federal Income Taxes	0		0	0
2.98	8027.7	Massachusetts Excise Tax	0		0	0
2.99	8030.0	Refunds and Allowances	0		0	0
2.101	8040.0	Adult Day Care Costs*	0		0	0
2.102	8065.0	Other Non-Nursing Costs*	0		0	0
2.2600	**8000.0**	**Total Bad Accts.-Taxes-Refunds-Day Care**	**0**		**0**	**0**
200	**4000.0**	**Total Expenses**	**4,907,356**	**0**	**(754,231)**	**4,153,135**
			A/C # 4000.0	**A/C #9945.0**	**A/C # 9939.0**	

Table 2C: Detail of Other Operating Expenses

Line #	Description	Amount
2C.1	FUNDRAISING EXPENSES	9,656
2C.3	BANK CHARGES	1,400
2C.4		
2C.100	**Total**	**11,056**

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**

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : Profit Loss Statement

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses

Table 3			1
Line #	Account #	Description	Amount
3.1	4000.0	Total Reported Operating Expenses	4,907,366
3.2	9945.0	Less: Self-Disallowed Expenses	0
3.3	9939.0	Less: Automatically Disallowed Expenses	(754,231)
3.100	**4001.1**	**Total Non-Allowable Expenses**	**(754,231)**
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	788,812
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**	**788,812**
3.41	NA	Less: Recoverable Income (offsetting operating expenses)	906,735
300	**4002.0**	**Total Allowable Operating Expenses Claimed**	**4,035,212**

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	5,561,072
4.2	4000.0	Total Cost Report Expenses	4,907,366
4.100		**Net Income (Loss) Cost Report**	**653,706**
Financial Statement Net Income			
4.3		Financial Statement Reported Income	5,561,072
4.4		Financial Statement Reported Expenses	4,907,366
4.200		**Net Income (Loss) Financial Statement**	**653,706**
Variance			
4.5		Variance Between Cost Report and Financial Statements: Income	0
4.6		Variance Between Cost Report and Financial Statements: Expenses	0
4.7		Variance Between Cost Report and Financial Statements: Net Income	0
Reconciling Items			
4.8		Reconciline Item: Explain	
4.9		Reconciling Item: Explain	
4.10		Reconciling Item: Explain	
4.11		Reconciling Item: Explain	
4.12		Reconciling Item: Explain	
4.300		**Total Reconciling Items**	**0**
Reconciliation			
400		**Difference between Total Reconciling Items and Variance Between Cost Report and Financial Statements: Net Income *****	**0**

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	1,354
1.2	0212.5 & 0212.0	Massachusetts EAEDC	3,531
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	367
100	**0200.0**	**Total Resident Days January 1 - March 31**	**5,252**

Resident Days April 1 - June 30			
Table 2	Account #		1
Line #		**Payer Description**	**Reported Days**
2.1	0310.5 & 0310.0	DTA Days	1,522
2.2	0312.5 & 0312.0	Massachusetts EAEDC	3,460
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	325
200	**0300.0**	**Total Resident Days April 1 - June 30**	**5,307**

Resident Days July 1 - September 30			
Table 3	Account #		1
Line #		**Payer Description**	**Reported Days**
3.1	0410.5 & 0410.0	DTA Days	1,584
3.2	0412.5 & 0412.0	Massachusetts EAEDC	3,320
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	506
300	**0400.0**	**Total Resident Days July 1 - September 30**	**5,410**

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : RESIDENT DAYS

Resident Days October 1 - December 31

Table 4	Account #		1
Line #		**Payer Description**	**Reported Days**
4.1	0510.5 & 0510.0	DTA Days	1,592
4.2	0512.5 & 0512.0	Massachusetts EAEDC	3,367
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	460
400	**0500.0**	**Total Resident Days October 1 - December 31**	**5,419**

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	**6,052**
5.2	0612.5 & 0612.0	Massachusetts EAEDC	**13,678**
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	**1,658**
500	**0600.0**	**Total Annual Resident Days**	**21,388**

Additional Patient Day Information

Table 6		1	
Line #		**Description**	**Reported Admission/Community Support Days**
6.1	0140.0	Number of Admissions	
6.2	0150.0	Number of Discharges	
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	683,602			683,602					
1.2	Land HCF-2	0			0					
1.3	Building HCF-4	8,643,170			8,643,170	2.50%	216,079			216,079
1.4	Building HCF-2	0			0				-	0
1.5	Improvements HCF-4	6,213,238	94,287		6,307,525	5.00%	315,376			315,376
1.6	Improvements HCF-2	0			0	5.00%			-	0
1.7	Equipment HCF-4	585,453	23,966		609,419	10.00%	60,942			60,942
1.8	Equipment HCF-2	0			0	10.00%			-	0
1.9	Software/Limited Life Assets HCF-4	0			0	33.33%	0			0
1.10	Software/Limited Life Assets HCF-2	0			0	33.33%			-	0
100	**Total Claimed Fixed Asset Depreciation Expense**	**16,125,463**	**118,253**	**0**	**16,243,716**		**592,397**	**0**	**0**	**592,397**

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 *	196,415	-	196,415
2.2	MA Corporate Excise Tax - Non-Income Portion	0	-	0
2.3	Building Insurance	0	-	0
2.4	Real Estate Taxes	0	-	0
2.5	Personal Property Taxes	0	-	0
2.6	Other Claimed Fixed Assets**	0	-	0
200	**Total Claimed Fixed Asset Other Expenses**	**196,415**	**0**	**196,415**

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : CLAIMED FIXED ASSETS

Total Claimed Fixed Asset Expenses

Table 3		1	
Line #	Description	Total	
300	Total Fixed Assets Expenses Claimed	788,812	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)	1925 + improvements
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)	N/A			
5.2	Sale of Residential Care Facility to Unrelated Third Party	N/A			
5.3	Sale of Realty Company	N/A			

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)	N/A	Refer to regulation 101 CMR 204.08(1)(a)	
6.4	Did your facility file a petition with CHIA for an administrative adjustment for substantial capital expenditures during the year?	No	Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.5	If yes to question 6.4, provide the date of the petition. (MM/DD/YYYY)	N/A	Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.6	Were the substantial capital expenditures subject to a Determination of Need (DON) approval by the Department of Public Health (DPH)? If yes, complete DON Schedule below.	No	Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.7	If yes to question 6.6, list expenditures.	Equipment	Improvements	Limited Life Assets
		N/A		

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : CLAIMED FIXED ASSETS

Determination of Need (DON) Project Details					
Table 7		1			
Line #	**Description**	**Response**			
7.1	List the DON project number.	N/A			
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	Mortgage	EASTERN BANK	No	11/01/2017	11/01/2027		30,102	6,200,000	117,058		5,307,744		(193,496)			**5,114,248**	3.17%	196,415		**196,415**
1.2	Mortgage	CEDA & CITY OF BOSTON	No	06/17/2010				3,635,000			3,635,000					**3,635,000**				-
1.3																-				-
1.4																-				-
1.5																-				-
1.6																-				-
1.7																-				-
1.8																-				-
100	**TOTALS**								**117,058**	-						**8,749,248**		**196,415**	-	**196,415**
										(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	NONE						-		
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	00,000.0	00,000.0	-	-	-	-
		7110.2	7210.2	7310.2	4306.1	7410.2	7510.2	7610.2
1.2	Maintenance Staff	00,003.6	5.0	7423.6	275,088	20,854	-	11,064
		7111.2	7211.2	7311.2	5105.1	7411.2	7511.2	7611.2
1.3	Dietary Staff	00,000.0	0.0	0.0	-	-	-	-
		7112.2	7212.2	7312.2	5205.1	7412.2	7512.2	7612.2
1.4	Dietician	00,000.0	0.0	0.0	-	-	-	-
		7113.2	7213.2	7313.2	5231.1	7413.2	7513.2	7613.2
1.5	Laundry Staff	00,000.2	1.0	323.8	12,694	-	-	2,213
		7114.2	7214.2	7314.2	5310.1	7414.2	7514.2	7614.2
1.6	Housekeeping Staff	00,003.6	5.0	7433.8	186,927	18,900	-	11,064
		7115.2	7215.2	7315.2	5410.1	7415.2	7515.2	7615.2
1.7	Quality Assurance	00,000.0	0.0	0.0	-	-	-	-
		7116.2	7216.2	7316.2	6504.1	7416.2	7516.2	7616.2
1.8	Community Support Coordinator	00,000.0	0.0	0.0	-	-	-	-
		7119.2	7219.2	7319.2	6507.1	7419.2	7519.2	7619.2
1.9	Social Services Staff	00,000.3	1.0	572.0	25,847	-	-	2,208
		7120.2	7220.2	7320.2	6540.0	7420.2	7520.2	7620.2
1.10	Restorative - Indirect Salaries	00,000.0	0.0	0.0	-	-	-	-
		7121.2	7221.2	7321.2	7011.1	7421.2	7521.2	7621.2
1.11	Restorative - Direct Salaries	00,000.0	0.0	0.0	-	-	-	-
		7122.2	7222.2	7322.2	7012.1	7422.2	7522.2	7622.2
1.12	Recreational Staff	00,005.4	7.0	11246.8	351,103	59,422	-	15,491
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,001.0	1.0	2160.0	156,130	11,710	-	2,213
		7124.2	7224.2	7324.2	4110.1	7424.2	7524.2	7624.2
1.14	Officer	00,000.0	0.0	0.0	-	-	-	-
		7125.2	7225.2	7325.2	4125.1	7425.2	7525.2	7625.2
1.15	Clerical Staff	00,001.8	2.0	3836.5	181,662	11,630	-	4,426
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	00,000.8	1.0	1560.0	101,789	1,535	-	2,213
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	00,000.0	0.0	0.0	-	-	-	-
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,010.3	13.0	21477.3	601,264	82,940	-	28,766
		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	1146-00 · A/R - Employees - $212
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4100-02 · Investment Dividends Earned - $11,874
HCF-4	Profit or Loss Schedule	Line # 2.20 /Employee Benefits - Pensions	None
HCF-4	Profit or Loss Schedule	Lines # 1.5, 2.5, 3.5, 4.5/Veterans Administration and Other Public	None
HCF-4	Profit or Loss Schedule	Line # 2.6/ Other Claimed Fixed Assets	None
HCF-3 RH	Part III - Management Company Financial Information	Acct. #3650.0/Other Income	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #9321.1/Clerical	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #9323.7/Other Expenses	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #9399.6/Total Other Administrative, Variable & DON Costs	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #9379.0/Miscellaneous	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #9391.0/Other Property Costs	Not applicable
HCF-3 RH	Part III - Management Company Financial Information	Acct. #1980.0/Other	Not applicable
HCF-4	General	Line #1.30/Report of unpaid workers expenses	None
HCF-4	General	Line #1.31/Cost-splitting methodology for employees whose salaries are reported in more than one account.	None
HCF-4	General	Line # 1.32/Details of accrued expenses not related to the current cost report period.	None
HCF-4	Balance Sheet	Line # 3.10/ Other	1148-00 · A/R - Miscellaneous - ($2,789)
HCF-4	Balance Sheet	Line # 3.10/ Other	1148-15 · A/R Tenant - $148,457
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4101-00 · Realized Gains and Losses - ($5,758)
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4104-00 · Unrealized Gains and Losses - $176,727
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4290-00 · Donations - Unrestricted - $38,079
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4290-10 · Donations - General - $23,046
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4290-60 · Donations - Appeal - $12,052
HCF-4	Profit or Loss Schedule	Line # 1.15 /Endowment & Other Nonrecoverable Income	4291-04 · Resident Special Needs Fund Inc - $1,139
HCF-4	Disclosures	Table 5 / Line #5.9 / Sole Proprietor, Partnership,or Corporate Information	Caren Silverlieb
HCF-4	Disclosures	Table 5 / Line #5.9 / Sole Proprietor, Partnership,or Corporate Information	Trustee
HCF-4	Disclosures	Table 5 / Line #5.9 / Sole Proprietor, Partnership,or Corporate Information	% Time Devoted = 5.00%
HCF-4	Disclosures	Table 5 / Line #5.9 / Sole Proprietor, Partnership,or Corporate Information	Salary = $0.00
HCF-4	Profit or Loss Schedule	Line #2.4 / Group Life/Health - Other	Employer Taxes = $217,387
HCF-4	Profit or Loss Schedule	Line #2.4 / Group Life/Health - Other	Benefits = $206,991
HCF-4	Profit or Loss Schedule	Line #2.4 / Group Life/Health - Other	Administrative Allocation = $66,261

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	HANSEN HUNTER LLC	
1.2	Preparer's Last Name	WHITLOW	
1.3	Preparer's First Name	RAYMOND	
1.4	Preparer's Middle Name		
1.5	Title	REIMBURSEMENT DIRECTOR	
1.6	Street Address	7080 SW FIR LOOP STE 100	
1.7	City	PORTLAND	
1.8	State	OREGON	
1.9	Zip Code	97701	
1.10	Phone Number	971-201-7802	
1.11	Email Address	RWHITLOW@HHC-CPA.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:	5/1/2024	

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : CERTIFICATIONS

Certification by Owner, Partner, or Officer

Table 2		1	
2.1	Last Name	SEAMAN	
2.2	First Name	KATHY	
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.**	☑
2.6	Date of Authorization	5/1/2024	

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

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

The HCF-2 RH must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 6120.8 "Rent Expenses for Real Property". This schedule must be completed whenever rent is paid to an individual, partnership, realty trust or other entity whether affiliated or not with the residential care facility. The HCF-2 RH serves the dual purpose of being a report to the Center by the individual or business entity which owns the real property to accurately reflect the complete financial condition AND a claim for reimbursement.

Part I: Facility Specific Realty Company Information and Disclosures

Facility Information

Table 1		
Line #	Description	1
1.1	Realty Company Name	
1.2	FEIN	
1.3	Realty Company CBCAD #	
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 HCF-4 cost report. These tables must be completed in its entirety. When completing these tables the following definitions of direct and indirect beneficial owner apply: 1) A ***direct owner*** is defined as a person or entity having any rights or benefits of ownership and having ***an interest of record*** in ay partnership, joint venture, corporation or other entity; and 2) An ***indirect beneficial owner*** is defined as a person having any benefits or rights of ownership, either direct or indirect, through one or more intermediaries, through any understanding or relationship with a person or entity, ***resulting in benefits of ownership which are not of record***. It is incumbent upon the owner to fully disclose such interest. These tables MUST be completed in entirety.

Direct and Indirect Owners

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

Table 2	1	2	3	4	5
Line #	Owner Name (Last, First)	Address	Percent Ownership	Select Ownership Type	Direct or Indirect?
2.1					
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
Line #	Nursing and/or Rest Home	VFN	Name of Owner	Company Address	% Ownership
3.1					
3.2					
3.3					
3.4					
3.5					

Indebtedness

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

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

Related Party Transactions

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

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

Proprietor, Partnership, or Corporate Information

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

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

Five Highest Paid Salaries

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

Table 7	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Line #	Name	Title	% Time Devoted - Administrative	% Time Devoted - Plant Operation, Maintenance and Security	% Time Devoted - Medical Services	% Time Devoted - Other	Total Time (Must equal 100%)	Salary	Employee Benefits	Payroll Taxes	Workers' Comp.	Gr. Life/Health Ins.	Draw	Other	Total
7.1							0.000								-
7.2							0.000								-
7.3							0.000								-
7.4							0.000								-
7.5							0.000								-

Part II: Condensed Facility Specific Realty Company Financial Information

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

Table 1 ***Income***

Line #	Account #	Description	Reported Amount	Explanation
1.1	4030.0	Rent/Interest From Facility Record Income		
1.2	4620.0	Other Rental Income		
1.3	4630.0	Other Income		
1.4	4660.0	Recoverable Fund Asset Income		
100	**4000.0**	**Total Income Reported**	**0**	

Table 2 ***Expenses***

Line #	Account #	Description	Reported Amount	
2.1	5540.0	Real Estate Taxes		
2.2	5620.5	Personal Property Taxes		
2.3	5510.0	Long Term Interest (Mortgages & Notes schedule)	0	
2.4	5620.5	Working Capital Interest (Mortgages & Notes schedule)	0	
2.5	5550.0	Interest on Late Payments, Penalties		
2.6	5627.0	Other Expenses **		Explain:
2.7	5550.0	Depreciation: Building		
2.8	5560.0	Depreciation: Improvements		
2.9	5570.0	Depreciation: Equipment		
2.10	5575.0	Depreciation: Software/Limited Life Assets		
2.11	5580.0	Insurance: Building, Building Improvements, Equipment		
2.12	9999.0	Other Operating Expenses		Explain:
200	**9000.0**	**Total Expenses Reported**	**0**	

Table 3 ***Assets***

Line #	Account #	Description	Reported Amount	
3.1	1010.0	Cash - Checking Account		
3.2	1030.0	Cash - On hand		
3.3	1020.0	Cash - Other		
3.4	1100.0	Loans Receivable - Due from Officers/Owners		
3.5	1170.0	Loans Receivable - Due from Employees		
3.6	1180.0	Loans Receivable - Due from Subsidiaries/Affiliates		
3.7	1189.0	Other Loans Receivable		
3.8	1270.0	Prepaid Interest		
3.9	1280.0	Prepaid Insurance		
3.10	1600.0	Other Prepaid Expenses		Explain:
3.11	1910.0	Other Current Assets		Explain:
3.12	1610.0	Land – Cost		
3.13	1620.1	Building – Cost		
3.14	1622.2	Building – Accumulated Depreciation		
3.15	1621.1	Building Improvements – Cost		
3.16	1612.2	Building Improvements – Accumulated Depreciation		
3.17	1630.1	Other Improvements – Cost		
3.18	1632.2	Other Improvements – Accumulated Depreciation		
3.19	1651.1	Equipment – Cost		
3.20	1652.2	Equipment – Accumulated Depreciation		
3.21	1701.1	Motor Vehicles – Cost		
3.22	1702.2	Motor Vehicles – Accumulated Depreciation		
3.23	1710.1	Software/Limited Life Assets - Cost		
3.24	1712.2	Software/Limited Life Assets – Accumulated Depreciation		
3.25	1900.0	Other Deferred Charges and Other Non-Current Assets		
3.26	1970.0	Intangibles (Net of Puchase)		
3.27	1971.1	Mortgage Acquisition Cost		
3.28	1971.2	Accumulated Amortization of Mortgage Acquisition Cost		
300	**1000.0**	**Total Assets**	**0**	

Table 4 ***Liabilities***

Line #	Account #	Description	Reported Amount	
4.1	2110.0	Notes/Loans Payable to Officer, Owner, Related Parties		
4.2	2120.0	Notes/Loans Payable to Subsidiaries and Affiliates		
4.3	2130.0	Notes/Loans Payable to Banks		
4.4	2150.0	Other Short-Term Financing		
4.5	2500.0	Long-Term Debt, Current Portion *		
4.6	2600.0	Accrued Taxes – Realty and Management		
4.7	2200.0	Other Current Liabilities		
4.8	2610.0	Mortgages *		
4.9	2620.0	Other Long-Term Debt *		
400		**Total Liabilities**	**0**	

Table 5 ***Net Worth***

Line #	Account #	Description	Reported Amount	
5.1	3110.0	Proprietorship or Partnership Capital		
5.2	3120.0	Proprietor Drawings		
5.3	3130.0	Partnership/Member (LLC) Drawings		
5.4	3140.0	Contributions		
5.5	3150.0	Net Profit/(Loss) Year to Date		
5.6	3610.0	Capital Stock		
5.7	3630.0	Additional Paid in Capital		
5.8	3640.0	Treasury Stock		
5.9	3650.0	Retained Earnings		
500		**Total Net Worth**	**0**	
600		**Total Liabilities and Net Worth**	**0**	**Assets Equals Liabilities and Net Worth**

Part III: Facility Specific Realty Company Claimed Fixed Asset Expenses

Claimed Fixed Asset Depreciation Expenses

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

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

Claimed Other Fixed Asset Expenses

Table 2		1
Line #	Description	Claimed Fixed Asset Expenses - Realty Company (HCP-2 991
2.1	Long-Term Interest Claimed *	
2.2	MA Corporate Excise Tax - Non-Income 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**	0

Total Claimed Fixed Asset Expenses

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

Detail of Other Operating Expenses A/C # 9502.2

Table 4		1	2	3	
Line #	Describe Expense	Reported Expense	Amount Self Disallowed	Claimed Amount	
4.1	Utilities & Permits			0	
4.2	Management Fee			0	
4.3	Auto expense			0	
4.4				0	
4.5				0	
400	Total Other Operating Expenses	0	0	0	A/C # 9502.2
		A/C # 9590.0			

Part IV: Facility Specific Realty Company Mortgages and Notes Payable

SCHEDULE - Mortgages & Notes

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

Mortgages and Notes Supporting Fixed Assets

Table 1		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Line #	Select Type of Notes Payable	Lender Name	Related Party (Select Yes/No)	Date Mortgage Acquired	Due Date	Number of Months Amortized	Monthly Payments	Original Loan Amount	Mortgage Acquisition Costs	Amortization of Mortgage Acquisition Costs (A)	Beginning Loan Balance Jan 1	Beginning Balance - New Loans	Principal Payments	Pay Off Amount	Pay Off Date	Ending Loan Balance Dec 31	Interest Rate %	Interest Expense (B)	Period Expenses (C)	Total Fixed Interest (Amortization, Interest and Period Expenses) (A) + (B) + (C)
1.1																0				0
1.2																0				0
1.3																0				0
1.4																0				0
1.5																0				0
1.6																0				0
1.7																0				0
1.8																0				0
100	**TOTALS**								0	0						0		0	0	0
																Equals Sum of A/C #s 2160.0, 3550.0, and				Equals A/C # 9545.0

Working Capital Debt

Table 2		1	2	3	4	5	6	7	8	9
Line #	Lender Name	Related Party (Select Yes/No)	Beginning Balance Jan 1	New Loan Amount	Start Date	Principal Payment	Ending Balance Dec 31	Interest Rate %	Interest Expense
2.1							0		
2.2							0		
2.3							0		
2.4							0		
2.5							0		
2.6							0		
200	**TOTALS**								0
							Equals the sum of A/Cs 2110.0, 3120.0, 3130.0, and 3150.0		Equals A/C# 9595.5