

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: **8/21/2023**
 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 FY2022 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	5507588
1.2	Provider ID/MMIS ID	110063068/A
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2022
1.4	Name of Facility	PLEASANT STREET REST HOME
1.5	Street Address	144 PLEASANT STREET
1.6	City	ATTLEBORO
1.7	Zip	02703
1.8	Telephone	508-226-8616
1.9	Federal Employer Identification Number	04-2988990
1.10	Responsible Person's Name	PAUL E MORIN
1.11	Responsible Person's Email	pemorin@aol.com
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	PRESIDENT
1.13	List Name of Person to Receive Rate Notifications	PAUL E MORIN
1.14	List Email of Person to Receive Rate Notifications	pemorin@aol.com
1.15	Status (Select Profit/Non-Profit from Dropdown Menu)	Profit
1.16	Legal Status (Select from Dropdown Menu)	1. MA Corp-Chapter 156B
1.17	Does this facility have other business activities? If Yes, Explain in Table 1A.	No
1.18	Enter the number of Level IV licensed geriatric beds.	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)	02/09/1988
1.22	Has the facility had a change in long-term financing during this cost report year?	No
1.23	Is the facility managed by a management company?	No
1.24	If line 1.23 is Yes, list the COMB# of the management company as reported on the management company cost report.	
1.25	If line 1.23 is Yes, list the name of the management company as reported on the management company cost report.	
1.26	Are you completing the HCF-2 RH (Realty Company Report) Tab in this Excel Workbook?	Yes
1.27	List realty company name(s) as reported on each realty company cost report.	JULIANA MORIN
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	01/01/2022	12/31/2022	60
1B.2			
1B.3			

Contact Information

Table 2		1
Line #	Description	
2.1	Contact Person Name	PAUL E MORIN
2.2	Residential Care Facility or Firm Name	PLEASANT STREET REST HOME
2.3	Title	PRESIDENT
2.4	Street Address	144 PLEASANT STREET
2.5	City	ATTLEBORO
2.6	State	MA
2.7	Zip Code	02703
2.8	Phone Number	508-226-8616
2.9	Email Address	pemorin@aol.com

Preparer Information

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

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

3.12	Type of Accounting Service Performed	COMPILATION
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RESIDENTIAL CARE FACILITY FY2022 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 Line #	1 Owner Name (Last, First)	2 Address	3 Percent Ownership	4 Select Ownership Type	5 Select Direct or Indirect?
1.1	PLEASANT ST REST HOME, INC.	144 PLEASANT ST ATTLEBORO MA	100.0%	Corporation	Direct
1.2	JULIANA M MORIN	23003 FRIAR WOODLANDHILLS CA	100.0%	Person	Direct
1.3	PAUL E MORIN	23003 FRIAR WOODLANDHILLS CA		Person	Indirect
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 Line #	1 Nursing and/or Rest Home	2 VPN	3 Name of Owner	4 Company Address	5 % Ownership
2.1			0		
2.2			0		
2.3			0		
2.4			0		
2.5					

Indebtedness

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

Table 3 Line #	1 Select type of debt	2 Select Payable From	3 Original Debt Amount	4 Date Issued	5 Balance 12/31	6 Select Payable To	7 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 Line #	1 Entity/Person	2 Goods/Services	3 Billing/Compensation	4 Mark up	5 Cost	6 Account Posted	7 Name of Owner	8 % Ownership
4.1	PAUL E MORIN	SERVICES	180,000		180,000	4110.1	JULIANA M MORIN	100.00%
4.2					-			
4.3					-			
4.4					-			
4.5					-			
4.6					-			

Sole Proprietor, Partnership, or Corporate Information

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

Table 5 Line #	1 Select Owner, Partner, Officer	2 Owner Name	3 Owner Title	4 % Time Devoted	5 Salary	6 Employee Benefits	7 Payroll Taxes	8 Workers' Comp.	9 Gr. Life/Health Ins.	10 Draw	11 Other	12 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 Line #	1 Name	2 Title	3 % Time Devoted - Administrative	4 % Time Devoted - Plant Operation, Maintenance, and Security	5 % Time Devoted - Medical Services	6 % Time Devoted - Other	7 Total Time (Must equal 100%)	8 Salary	9 Employee Benefits	10 Payroll Taxes	11 Workers' Comp.	12 Gr. Life/Health Ins.	13 Draw	14 Other	15 Total
6.1	ELAINE WALKER	COORDINATOR	100.00%				100.00%	121,041		9,683	363				131,087
6.2	GENOVEVA DIAS	AIDE			100.00%		100.00%	87,908		7,472	1,231				96,611
6.3	SARAH CHOY	AIDE			100.00%		100.00%	42,854		3,624	597				46,855
6.4	GREG KOLE	DIETARY				100.00%	100.00%	41,020		3,487	574				45,081
6.5	PAUL E MORIN	ADMIN	100.00%				100.00%	180,000		14,400	540				194,940

RESIDENTIAL CARE FACILITY FY2022 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	38,140
1.2	1030.0	Cash - On Hand	0
1.3	1040.0	Temporary Investments	421,482
1.4	1050.0	Other Cash	0
1.100	1010.0	Total Cash and Cash Equivalents	459,622
		Accounts Receivable	
1.5	1080.0	Private Patients	-
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	96,251
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	96,251
		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	54,000
1.300	1150.0	Total Loans Receivable	54,000
1.14	1190.0	Interest Receivable	-
1.15	1210.0	Supply Inventory	3,000
		Prepaid Expenses	
1.16	1270.0	Prepaid Interest	-
1.17	1280.0	Prepaid Insurance	8,946
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	8,946
1.21	1310.0	Other Current Assets	-
100	1005.0	Total Current Assets	621,819

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			
2.2	1520.0	Building	-	-	0
2.3	1610.0	Building Improvements	218,236	(95,055.00)	123,181
2.4	1625.0	Leasehold Improvements	-	-	0
2.5	1630.0	Other Improvements	-	-	0
2.6	1650.0	Equipment	104,300	(73,233.00)	31,067
2.7	1700.0	Motor Vehicles	-	-	0
2.8	1710.0	Software/Limited Life Assets	-	-	0
200	1500.0	Total Non-Current Fixed Assets			154,248

Deferred Charges and Other Assets

Table 3			1
Line #	Account #	Description	Account Balance
3.1	1910.0	Organization Expense	-
3.2	1940.0	Purchased Goodwill	-
3.3	1950.0	Leasehold Deposits	-
3.4	1960.0	Utility Deposits	-
3.5	1970.0	Cash Surrender Value of Officer Life Insur.	-
3.6	1975.1	Mortgage Acquisition Costs *	-
3.7	1975.2	Accumulated Amortization of Mortgage Acquisition Costs	-

3.8	1975.0	Unamortized Mortgage Acquisition Costs	-
3.9	1979.0	Construction in Progress *	-
3.10	1980.0	Other **	-
3.100	1900.0	Total Deferred Charges and Other Assets	-
300	1000.0	Total Assets	776,067

Current Liabilities			
Table 4			
Line #	Account #	Description	1 Account Balance
		Accounts Payable	
4.1	2020.0	Trade Payables	28,671
4.2	2030.0	Accrued Expenses	1,800
4.3	2047.0	Due to Commonwealth of MA	-
4.100	2010.0	Total Accounts Payable	30,471
4.4	2050.0	Patient Funds Due	-
		Notes and Loans Payable (See Mortgages & Notes Schedule)	
4.5	2110.0	Officer, Owner, or Related Parties	-
4.6	2120.0	Subsidiaries and Affiliates	-
4.7	2130.0	Banks	-
4.8	2140.0	Motor Vehicles	-
4.9	2150.0	Other Short-Term Financing	-
4.10	2160.0	Payment Due Within One Year on Long-Term Debt *	-
4.200	2100.0	Total Notes and Loans Payable	-
		Accrued Salaries and Payroll Liabilities	
4.11	2190.0	Accrued Salaries	21,982
4.12	2200.0	Accrued Payroll Tax Withheld	-
4.13	2210.0	Accrued Employee Taxes Payable	-
4.14	2220.0	Other Payroll Liabilities	-
4.300	2180.0	Total Accrued Salaries and Payroll Liabilities	21,982
		Other Current Liabilities	
4.15	2260.0	State and Federal Taxes Payable	943
4.16	2270.0	Accrued Interest Payable	-
4.17	2290.0	Other Current Liabilities	-
4.400	2250.0	Total Other Current Liabilities	943
400	2005.0	Total Current Liabilities	53,396

Long-Term Liabilities			
Table 5			
Line #	Account #	Description	1 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	53,396

Net Worth			
Table 6			
Line #	Account #	Description	1 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	1,000
6.6	2630.0	Additional Paid in Capital	0
6.7	2640.0	Treasury Stock	0
6.8	2650.0	Retained Earnings	721,671
6.200	2610.0	Total Corporation Capital	722,671
600	2000.0	Total Liabilities and Net Worth	776,067

Balance Sheet Check			
Table 7			
Line #	Account #	Description	1 Account Balance
7.1	1000.0	Total Assets	776,067

7.2	2000.0	Total Liabilities and Net Worth	776,067
		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 FY2022 COST REPORT (HCF-4)

SCHEDULE - Profit Loss Statement

Gross Income			
Line #	Account #	Description	Reported Amount
1.1	3021.1	Private	0
1.2	3022.5	DTA	850,148
1.3	3022.8	MA DTA Patient Resource Income	4,424,681
1.4	3022.7	Non-MA DTA	0
1.5	3023.1	MA Commission for the Blind	0
1.6	3023.2	Va and Other Public	0
1.7	3025.1	Adult Day Care Income	0
1.8	3026.2	Other Non-Nursing Income	0
1.9		(COVID-Related Supplemental Payments)	51,829
Ancillary Services (Use Table 1A to Right to Remove Expenses)			
1.10	3033.1	Private	0
1.11	3033.5	Medicaid (DMA)	0
1.12	3032.7	Non-MA Medicaid	0
1.13	3033.1	MA Commission for the Blind	0
1.14	3033.3	Va & Other Public	0
1.100	3030.0	Total Ancillary Services	0
Miscellaneous and Recoverable Income			
1.15	3120.1	Endowment & Other Nonrecoverable **	0
1.16	3140.0	Laundry Recoverable Income	0
1.17	3150.0	Vending Machines Recoverable Income	0
1.18	3160.0	Real Estate Recovery	0
1.19	3170.0	Prior Year Retrospective Adjustment	267
1.20	3180.0	Interest Income	0
1.21	3190.0	Operating Costs Recoverable	0
1.22	3195.0	Field Costs Recoverable	267
1.200	3130.0	Total Miscellaneous and Recoverable Income	534
100	3000.0	Total Gross Income	2,307,372

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				
Line #	Account #	Description	Reported Expenses	Self Disallowed Expenses (955.0)
Administrative Expenses				
2.1	4110.1	Administrative/Responsible Person Salaries	180,908	0
2.2	4125.1	Officer Salaries *	0	0
Other Expenses				
2.3	4140.1	General Salaries (Use Table 2A to Right to Remove Salaries)	26,182	36,182
2.4	4150.3	Electronic Data Processing, Payroll, and Bookkeeping Services	9,859	9,859
2.5	4160.3	Management Fees	0	0
2.6	4160.6	Management Consultants*	0	0
2.100	4120.0	Total Other Expenses	36,041	46,041
2.200	4190.0	Total Administrative Expenses	246,949	0
General Supplies & Expenses				
2.7	4250.5	Office Supplies	6,747	6,747
2.8	4261.5	Phone	0	0
2.9	4262.4	Director Advertising	0	0
2.300	4260.0	Total Telephone Expenses	0	0
Travel Expenses				
2.10	4275.5	Motor Vehicle Expenses*	5,720	5,720
2.11	4280.5	Conventions and Meetings	0	0
2.400	4270.5	Total Travel Expenses	5,720	5,720
Advertising Expenses				
2.12	4295.7	Help Wanted	504	504
2.13	4298.7	Promotional	0	0
2.500	4290.0	Total Advertising Expenses	504	0
Licenses and Fees Expenses				
2.14	4301.7	Licenses and Fees: Patient Care Related Portion	4,794	4,794
2.15	4302.3	Licenses and Fees: Not Related to Patient Care	0	0
2.600	4300.0	Total Licenses and Fees Expenses	4,794	0
Education and Training Expenses				
2.16	4306.1	Staff Development- Coordinator Salary	0	0
2.17	4306.2	Administration Training	0	0
2.18	4306.3	Other Required Education	0	0
2.19	4306.4	Job Related Education	0	0
2.700	4300.0	Total Education and Training Expenses	0	0
Employee Benefits				
2.20	4310.1	Employee Benefits - Pensions **	0	0
2.21	4310.2	Employee Benefits - Other	0	0
2.22	4319.2	Officer Profit Sharing and Other Benefits	0	0
2.800	4310.0	Total Employee Benefits	0	0
Accounting Expenses				
2.23	4350.3	Accounting- Appraisal Services	0	0
2.24	4360.3	Accounting- Other (Use Table 2B to Right to Remove Expenses)	9,650	9,650
2.900	4340.0	Total Accounting Expenses	9,650	0
Legal Expenses				
2.25	4380.3	Legal- Appraisal Service	0	0
2.26	4380.7	Legal- Division of Administrative Law Apprais - Filing Fees	0	0
2.27	4390.7	Other Legal	0	0
2.1000	4370.0	Total Legal Expenses	0	0
Payroll Taxes				
2.28	4411.1	Payroll Taxes - Other	93,585	93,585
2.29	4411.2	Payroll Taxes - Officers	0	0
2.1100	4400.0	Total Payroll Taxes	93,585	0
Insurance Expense				
2.30	4428.7	Insurance- Department of Unemployment Assistance Claims (DUAC) - A&G Portion	0	0
2.31	4430.7	Insurance- Malpractice and General Liability *	39,904	39,904
2.32	4432.7	Key Person Insurance	0	0
2.33	4530.8	Insurance- Building Improvements and Equipment	(5,952)	0
2.34	4424.1	Workers' Comp - Other	15,748	15,748
2.35	4424.2	Workers' Comp - Officers	0	0
2.36	4426.1	Group Life/Health - Other	0	0
2.37	4426.2	Group Life/Health - Officers	0	0
2.1200	4420.0	Total Insurance Expenses	61,504	(5,952)
2.38	4415.0	Interest on Late Payments, Penalties	0	0
2.39	4430.0	Interest on Working Capital	895	(895)
2.40	4430.0	Pre-Opening Expenses	0	0
2.41	4443.00	Other Operating Expenses (Use Table 2C to Right to Remove Expenses)	3,850	3,850
2.1300	4200.0	Total General Supplies and Expenses	187,243	(6,847)
Real Estate Taxes				
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	(698,400)	0
2.46	4538.8	Other Rent (Use Table 2D to Right to Remove Expenses)	0	0
2.47	4550.8	Depreciation - Building	4,184	(4,184)
2.48	4562.8	Depreciation - Building Improvements	6,928	(6,928)
2.49	4567.8	Depreciation - Leasehold Improvements	0	0
2.50	4568.8	Depreciation - Other Improvements	0	0
2.51	4570.8	Depreciation - Equipment	8,743	(8,743)
2.52	4585.8	Depreciation - Software/Limited Life Assets	0	0
2.1400	4540.0	Total Fixed Costs	718,253	(718,253)
Plant Operations, Maintenance & Security				
2.53	5105.1	Plant Operations, Maintenance & Security - Salaries	60,152	60,152
2.54	5110.1	Plant Operations, Maintenance & Security - Purchased Service	18,392	18,392
2.55	5115.5	Plant Operations, Maintenance & Security - Supplies and Expenses	65,533	65,533
2.56	5120.5	Plant Operations, Maintenance & Security - Utilities	108,841	108,841
2.57	5130.7	Plant Operations, Maintenance & Security - Repairs	59,145	59,145
2.1500	5100.0	Total Plant Operation, Maintenance & Security	310,043	0
Dietary				
2.58	5205.1	Dietary - Salaries	210,343	210,343
2.59	5205.5	Dietary - Food	127,796	127,796
2.60	5211.3	Dietary - Purchased Service	624	624
2.61	5231.1	Dietician - Salary	0	0
2.62	5233.3	Dietician - Purchased Service	3,960	3,960
2.63	5275.5	Dietary - Supplies and Expenses	0	0
2.1600	5200.0	Total Dietary	342,833	0
Laundry				
2.64	5310.1	Laundry - Salaries	0	0
2.65	5320.3	Laundry - Purchased Service	0	0
2.66	5330.5	Laundry - Supplies and Expenses	0	0
2.67	5340.5	Laundry - Linen and Bedding	2,682	2,682
2.1700	5300.0	Total Laundry	2,682	0
Housekeeping				
2.68	5410.1	Housekeeping - Salaries	254,880	254,880
2.69	5415.3	Housekeeping - Purchased Service	0	0
2.70	5420.5	Housekeeping - Supplies and Expenses	0	0
2.1800	5400.0	Total Housekeeping	254,880	0
Nursing				
Registered Nurses				
2.71	6030.1	RN Salaries	0	0
2.72	6035.1	RN Purchased Service	0	0
2.73	6041.1	LPN Salaries	0	0
2.74	6043.1	LPN Purchased Service	0	0
Nurses Aides				
2.75	6051.1	Nurses Aides Salaries	266,863	266,863
2.76	6052.1	Nurses Aides Purchased Service	4,379	4,379
2.1900	6000.0	Total Nursing	271,241	0
Medical Services				
2.77	6504.1	Quality Assurance Professional	0	0
2.78	6507.1	Community Support Coordinator	87,321	87,321
Physicians' Services				
2.80	6554.1	Employee Physicals	0	0
2.80	6515.1	Other Medical Services Expenses (Use Table 2E to Right to Remove Expenses)	0	0
2.2000	6510.0	Total Physicians' Services	0	0

Table 2A: Detail of Clerical Salaries				
Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1	ELAINE WALKER	OFFICE MANAGER	REIDENT RECORDS	24,208
2A.2	SEBRA MAHAN	CLERICAL	REIDENT RECORDS	31,970
2A.3				0
2A.4				0
2A.5				0
2A.6				0
2A.7				0
2A.8				0
2A.9				0
2A.10				0
2A.11				0
2A.12				0
2A.13				0
2A.14				0
2A.15				0
2A.16				0
2A.100			Total Clerical Salaries	56,182

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 I: Purchased Service Accounting Expenses				
Line #	Vendor Name	Date Occurred (MM/DD/YYYY)	Amount	Select Code
2B.1	PETER B. PLUMB, CPA	12/31/2022	5,850	A
2B.2	PETER B. PLUMB, CPA	12/31/2022	1,000	D
2B.3	PETER B. PLUMB, CPA	12/31/2022	3,000	C
2B.4				
2B.5				
2B.100		Sub-Total	9,850	
Part II: Employee's Responsibilities Only				
Line #	Employee Name	Job Title	Salary	Select Code
2B.6				
2B.7				
2B.8				
2B.9				
2B.200		Sub-Total	0	
2B.300		Total Other Accounting	9,850	

Accounting Expense Codes			
A. HCF-4 Cost Report Prep	B. Personal Tax Prep	C. SEC Filings	
D. Medicare Cost Report Prep	E. Management Advisory Services	F. Other Allowable Accounting (Explain)	
G. Corporate Tax Prep	H. Certified Financial Statement Audit	I. Other Non-Allowable Accounting (Explain)	

Table 2C: Detail of Other Operating Expenses		
Line #	Description	Amount
2C.1	CONTRIBUTIONS	0
2C.2	TRAVEL EXPENSES	3,850
2C.4	0	0
2C.100	Total	3,850

Table 2D: Detail of Other Rent Expenses		
Line #	Description	Amount
2D.1	Equipment Rental	0
2D.2	0	0
2D.3	0	0
2D.100	Total	0

Table 2E: Detail of Other Medical Services Expenses		
Line #	Description	Amount
2E.1		0
2E.2		0

Medical Supplies & Drugs			
2.81	6520.5	Legume Drugs	0
2.82	6522.5	House Supplies Not Resold	33,055
2.83	6523.5	Resold to Private Patients	0
2.2300	6520.0	Total Medical Supplies and Drugs	33,055
2.84	6530.0	Pharmacy Consultants	0
2.85	6540.0	Social Service Worker (Including Behavioral Health)	0
2.2200	6500.0	Total Medical Services	130,376
Restorative & Recreational Therapy			
Restorative Therapy			
2.86	7011.1	Indirect Restorative Therapy Salaries	0
2.87	7012.1	Direct Restorative Therapy Salaries	0
2.88	7012.2	Direct Restorative Therapy Benefits	0
2.89	7013.3	Indirect Restorative Therapy Consultants	0
2.90	7014.3	Direct Restorative Therapy Consultants	0
2.2300	7010.0	Total Restorative Therapy	0
Recreational Therapy			
2.91	7021.1	Recreational Therapy - Salaries	0
2.92	7022.3	Recreational Therapy - Purchased Service	0
2.93	7023.5	Recreational Therapy - Supplies and Expenses	233
2.94	7024.8	Recreational Therapy - Transportation	0
2.2400	7020.0	Total Recreational Therapy	233
2.2500	7000.0	Total Restorative & Recreational Therapy	233
Bad Accts - Taxes-Refunds-Day Care			
2.95	8010.0	Bad Accounts - Refunds, Taxes, Day Care	0
2.96	8015.0	Fines, Late Charges, and Penalties	0
2.97	8025.5	State & Federal Income Taxes	1,103
2.98	8027.7	Massachusetts Excise Tax	456
2.99	8030.0	Refunds and Allowances	0
2.100	8040.0	Adult Day Care Costs*	0
2.103	8065.0	Other Non-Nursing Costs*	0
2.2600	8000.0	Total Bad Accts.-Taxes-Refunds-Day Care	1,559
200	4000.0	Total Expenses	2,405,368
		A/C # 4000.0	A/C #9945.0
			A/C # 9935.0

26.3		0
26.4		0
26.100	Total	0

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses		
Table 3		1
Line #	Account #	Description
3.1	4000.0	Total Reported Operating Expenses
3.2	9945.0	Less: Self-Disallowed Expenses
3.3	9935.0	Less: Automatically Disallowed Expenses
3.100	4091.1	Total Non-Allowable Expenses
3.4	9960.1	Allocated Administrative and General From Management Company (HCF-3)
3.5	9962.2	Other Operating Expense Add-Back from Realty Company (HCF-2 8th)
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	9950.0	Claimed Fixed Asset Expenses from Claimed Fixed Assets Schedule
3.9	9962.6	Allocated Direct Variable (Director, Indirect Therapy & CNA) Management Company Add-Back Expenses
3.10	9962.8	Allocated Direct Director of Nurses Management Company Add-Back Expenses
3.200	4061.2	Total Allowable Add-Back Expenses
3.41	NA	Less: Recoverable income (including operating expenses)
300	4060.0	Total Allowable Operating Expenses Claimed

Reconciliation of Cost Report Net Income to Financial Statement (Book) Net Income		
Table 4		1
Line #	Account #	Description
Cost Report Net Income		
4.1	3000.0	Total Cost Report Income
4.2	2000.0	Total Cost Report Expenses
4.100	NA	Net Income (Loss) Cost Report
Financial Statement Net Income		
4.3		Financial Statement Reported Income
4.4		Financial Statement Reported Expenses
4.200	NA	Net Income (Loss) Financial Statement
Variance		
4.5		Variance Between Cost Report and Financial Statements: Income
4.6		Variance Between Cost Report and Financial Statements: Expenses
4.7		Variance Between Cost Report and Financial Statements: Net Income
Reconciling Items		
4.8		
4.9		Reconciling Item: Explain 4.3 & 4.4 CELLS LOCKED ABOVE - PASS ON
4.10		Reconciling Item: Explain
4.11		Reconciling Item: Explain
4.12		Reconciling Item: Explain
4.300	NA	Total Reconciling Items
Reconciliation		
400		Difference between Total Reconciling Items and Variance Between Cost Report and Financial Statements: Net Income ***

Footnote Legend
 * Preparer is to refer to the instruction guide for properly completing this line. A link to the instructions is provided in the User Guide Tab.
 ** Preparer is required to provide details in the Footnotes schedule of this cost report.
 *** This should be zero. The variance in the net income should be accounted for by the reconciling items.

RESIDENTIAL CARE FACILITY FY2022 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	2,742
1.2	0212.5 & 0212.0	Massachusetts EAEDC	2,430
1.3	0215.4 & 0215.0	Non-Massachusetts DTA	
1.4	0260.5 & 0260.0	MA Commission for the Blind	
1.5	0270.5 & 0270.0	Veterans Administration and Other Public **	
1.6	0290.5 & 0290.0	Private	
100	0200.0	Total Resident Days January 1 - March 31	5,172

Resident Days April 1 - June 30

Table 2	Account #		1
Line #		Payer Description	Reported Days
2.1	0310.5 & 0310.0	DTA Days	2,772
2.2	0312.5 & 0312.0	Massachusetts EAEDC	2,457
2.3	0315.4 & 0315.0	Non-Massachusetts DTA	
2.4	0360.5 & 0360.0	MA Commission for the Blind	
2.5	0370.5 & 0370.0	Veterans Administration and Other Public **	
2.6	0390.5 & 0390.0	Private	
200	0300.0	Total Resident Days April 1 - June 30	5,229

Resident Days July 1 - September 30

Table 3	Account #		1
Line #		Payer Description	Reported Days
3.1	0410.5 & 0410.0	DTA Days	2,668
3.2	0412.5 & 0412.0	Massachusetts EAEDC	2,576
3.3	0415.4 & 0415.0	Non-Massachusetts DTA	
3.4	0460.5 & 0460.0	MA Commission for the Blind	
3.5	0470.5 & 0470.0	Veterans Administration and Other Public **	
3.6	0490.5 & 0490.0	Private	
300	0400.0	Total Resident Days July 1 - September 30	5,244

Resident Days October 1 - December 31

Table 4	Account #		1
Line #		Payer Description	Reported Days
4.1	0510.5 & 0510.0	DTA Days	2,668
4.2	0512.5 & 0512.0	Massachusetts EAEDC	2,668
4.3	0515.4 & 0515.0	Non-Massachusetts DTA	
4.4	0560.5 & 0560.0	MA Commission for the Blind	
4.5	0570.5 & 0570.0	Veterans Administration and Other Public **	
4.6	0590.5 & 0590.0	Private	
400	0500.0	Total Resident Days October 1 - December 31	5,336

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	10,850
5.2	0612.5 & 0612.0	Massachusetts EAEDC	10,131
5.3	0615.4 & 0615.0	Non-Massachusetts DTA	0
5.4	0660.5 & 0660.0	MA Commission for the Blind	0
5.5	0670.5 & 0670.0	Veterans Administration and Other Public **	0
5.6	0690.5 & 0690.0	Private	0
500	0600.0	Total Annual Resident Days	20,981

Additional Patient Day Information

Table 6		1	
---------	--	---	--

Line #		Description	Reported Admission/Community Support Days
6.1	0140.0	Number of Admissions	10
6.2	0150.0	Number of Discharges	10
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 FY2022 COST REPORT (HCF-4)

SCHEDULE : CLAIMED FIXED ASSETS

Claimed Fixed Asset Expenses

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

Table 1		1	2	3	4	5	6	7	8	9
Line #	Description	Allowable Cost Basis Beginning Balance	Claimed Additions	Claimed Deletions	Allowable Cost Basis Ending Balance	Depreciation %	Depreciation HCF-4	Non-Allowable Depreciation Expense	Add-Backs from HCF-2 RH if applicable	Claimed Net Depreciation Expense
1.1	Land HCF-4			0	0					
1.2	Land HCF-2	15,161		0	15,161					
1.3	Building HCF-4			0	0	2.50%	0			0
1.4	Building HCF-2	207,145		0	207,145	2.50%			9,798	9,798
1.5	Improvements HCF-4	218,236		0	218,236	5.00%	10,912			10,912
1.6	Improvements HCF-2			0	0	5.00%			-	0
1.7	Equipment HCF-4	87,468		0	87,468	10.00%	8,747			8,747
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	528,010	0	0	528,010		19,659	0	9,798	29,457

Other Claimed Fixed Asset Expenses

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

Table 2		1	2	3
Line #	Description	Claimed Fixed Asset Expenses - Rest Home (HCF-4)	Claimed Fixed Asset Expenses - Realty Company (HCF-2 RH)	Total Other Claimed Fixed Asset Expenses
2.1	Long-Term Interest Claimed *	0	-	0
2.2	MA Corporate Excise Tax - Non-Income Portion	456	-	456
2.3	Building Insurance	5,952	-	5,952
2.4	Real Estate Taxes	0	17,467	17,467
2.5	Personal Property Taxes	0	-	0
2.6	Other Claimed Fixed Assets**		-	0
200	Total Claimed Fixed Asset Other Expenses	6,408	17,467	23,875

Total Claimed Fixed Asset Expenses

Table 3		1
Line #	Description	Total
300	Total Fixed Assets Expenses Claimed	53,332

A/C 9500.0

General Fixed Cost Information

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

Changes in Facility or Realty Company Ownership

Table 5	1	2	3	4	5
Line #	Select Type of Ownership Change	Transaction Date	Purchased From	Purchased By	Sale Price

5.1	Sale of Residential Care Facility Between Current Owners (e.g. related parties)				
5.2	Sale of Residential Care Facility to Unrelated Third Party				
5.3	Sale of Realty Company				

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

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

Footnote Legend

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

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

RESIDENTIAL CARE FACILITY FY2022 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.

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								-	-						-		-	-	-

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	INTEREST ON CREDIT CARDS		-	-		-	-		895
2.2									
2.3			-	-			-		
2.4							-		
2.5							-		
2.6							-		
200	TOTALS								895
							A/C # 2100.0 less 2160.0		A/C # 4430.0

RESIDENTIAL CARE FACILITY FY2022 COST REPORT (HCF-4)

SCHEDULE : WAGES AND BENEFITS

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

Table 1		1	2	3	4	5	6	7
Line #	Description	Number of FTE (Round to one decimal place)	Number of Staff (Round to one decimal place)	Total Hours (Round to one decimal place)	Total Salaries	Group Life/Health Benefits	Pensions	Other Benefits
1.1	Staff Development	#VALUE!			-			
		7110.2	7210.2	7310.2	4306.1	7410.2	7510.2	7610.2
1.2	Maintenance Staff	00,001.4	2.0	2856.0	60,152			
		7111.2	7211.2	7311.2	5105.1	7411.2	7511.2	7611.2
1.3	Dietary Staff	00,005.9	10.0	12289.0	210,343			
		7112.2	7212.2	7312.2	5205.1	7412.2	7512.2	7612.2
1.4	Dietician	#VALUE!			-			
		7113.2	7213.2	7313.2	5231.1	7413.2	7513.2	7613.2
1.5	Laundry Staff	#VALUE!			-			
		7114.2	7214.2	7314.2	5310.1	7414.2	7514.2	7614.2
1.6	Housekeeping Staff	00,006.2	4.0	12800.0	194,880			
		7115.2	7215.2	7315.2	5410.1	7415.2	7515.2	7615.2
1.7	Quality Assurance	#VALUE!			-			
		7116.2	7216.2	7316.2	6504.1	7416.2	7516.2	7616.2
1.8	Community Support Coordinator	00,000.9	1.0	1925.0	97,321			
		7119.2	7219.2	7319.2	6507.1	7419.2	7519.2	7619.2
1.9	Social Services Staff	#VALUE!			-			
		7120.2	7220.2	7320.2	6540.0	7420.2	7520.2	7620.2
1.10	Restorative - Indirect Salaries	#VALUE!			-			
		7121.2	7221.2	7321.2	7011.1	7421.2	7521.2	7621.2
1.11	Restorative - Direct Salaries	#VALUE!			-			
		7122.2	7222.2	7322.2	7012.1	7422.2	7522.2	7622.2
1.12	Recreational Staff	#VALUE!			-			
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,000.7	1.0	1533.0	180,908			
		7124.2	7224.2	7324.2	4110.1	7424.2	7524.2	7624.2
1.14	Officer	#VALUE!			-			-
		7125.2	7225.2	7325.2	4125.1	7425.2	7525.2	7625.2
1.15	Clerical Staff	00,000.3	1.0	520.0	56,182			
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	#VALUE!			-			
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	#VALUE!			-			
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,006.2	17.0	12891.0	266,863			
		7131.2	7231.2	7331.2	6051.1	7431.2	7531.2	7631.2

RESIDENTIAL CARE FACILITY FY2022 COST REPORT (HCF-4)

SCHEDULE : FOOTNOTES AND EXPLANATIONS

[illegible]

[illegible]

RESIDENTIAL CARE FACILITY FY2022 COST REPORT (HCF-4)

SCHEDULE : CERTIFICATIONS

Certification by Preparer (Other than Owner, Partner, or Officer)

Table 1		1
1.1	Firm Name / Realty Company	PETER B. PLUMB, CPA
1.2	Preparer's Last Name	PLUMB
1.3	Preparer's First Name	PETER
1.4	Preparer's Middle Name	B.
1.5	Title	CPA
1.6	Street Address	83 CHURCH ST
1.7	City	WHITINSVILLE
1.8	State	MA
1.9	Zip Code	01588
1.10	Phone Number	508-234-8311
1.11	Email Address	peter@1040.org
1.12	By checking this box and completing line 1.13, Date of Authorization, I hereby certify that I am the Preparer of this report noted above and I attest, to the best of my knowledge and belief, that this cost report is a true, correct, and complete statement. This report is subject to audit and verification by the Center for Health Information and Analysis.	
1.13	Date of Authorization:	8/21/2023

☒

Certification by Owner, Partner, or Officer

Table 2		1
2.1	Last Name	MORIN

2.2	First Name	PAUL	
2.3	Middle Name	E	
2.4	Title	PRESIDENT	
2.5	By checking this box and completing line 2.6, Date of Authorization, I declare and affirm under the penalties of perjury that this cost report and supporting schedules have been examined by me and, to the best of my knowledge and belief, are a true and correct statement of total operating expenditures, balance sheet, earnings and expenses, and other required information. Further, I declare that the report and supplemental information were prepared from the books and records of the provider, unless otherwise noted, in accordance with applicable federal and state laws, regulations and instructions. I understand that any payment resulting from this report will be from state and federal funds and that any false statements or documents, or the concealment of a material fact, may be prosecuted under applicable federal and state laws. I also understand that this report and supporting schedules are subject to audit and verification by the Center for Health Information and Analysis or any other state or federal agency or their subcontractors. I will keep all records, books, and other information pertaining to this cost report for a period of five years. If there is an unresolved audit exception, I will keep these records until all issues are resolved.		☒
2.6	Date of Authorization	8/21/2023	

RESIDENTIAL CARE FACILITY FY2022 COST REPORT (HCF-4)

SCHEDULE - Condensed Realty Company Cost Report (HCF-2 B9)

The HCF-2 B9 must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 8525, "Net Expenses for Real Property". This schedule must be completed whenever rent is paid to an individual, partnership, trust, trust or other entity whether affiliated or not with the residential care facility. The HCF-2 B9 covers the fiscal year of the report to the Center by the individual or business entity which owns the real property to accurately reflect the complete financial condition AND a cash for reimbursement.

Part I: Facility Specific Realty Company Information and Disclosures

Facility Information

Line #	Description	1
1.1	Realty Company Name	Location Address
1.2	City	
1.3	Realty Company Address	Address
1.4	Realty Company Address	Address
1.5	Realty Company Address	Address
1.6	City	
1.7	State	
1.8	Zip	
1.9	Telephone	

IMPORTANT: Tables 2 through 4 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 any 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 interests. These tables MUST be completed in its entirety.

Direct and Indirect Owners

List all direct and indirect owners with an interest of 1% or more in this realty company. If the realty company is owned by a corporation, club, or trust, list the name of the corporation, club, or trust, and the name of the owner.

Line #	Owner Name (Last, First)	Address	Percent Ownership	Select Ownership Type	Direct or Indirect
2.1	JOHN DOE (100%)	12345 Main St, Anytown, MA 01234	100%	Individual	Direct
2.2	JANE DOE (100%)	12345 Main St, Anytown, MA 01234	100%	Individual	Direct
2.3	ABC COMPANY (100%)	12345 Main St, Anytown, MA 01234	100%	Corporation	Indirect
2.4	DEF COMPANY (100%)	12345 Main St, Anytown, MA 01234	100%	Corporation	Indirect
2.5	GHI COMPANY (100%)	12345 Main St, Anytown, MA 01234	100%	Corporation	Indirect
2.6	JKL COMPANY (100%)	12345 Main St, Anytown, MA 01234	100%	Corporation	Indirect

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 1% or more.

Line #	Facility Name and Address	1	2	3	4	5
3.1						
3.2						
3.3						
3.4						
3.5						

Indebtedness

List any indebtedness (mortgages, deeds, trust instruments, notes, or other financial instruments) 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.

Line #	Select type of debt	Select Payable Date	Original Debt Amount	Date Issued	Balance (12/31)	Select Payable To	List Owners Name
4.1							
4.2							
4.3							
4.4							
4.5							
4.6							

Related Party Transactions

Indicate any entity, person, or related party as defined in 48C CFR 204.10 and that (a) provides services, facilities, goods and/or supplies to this realty company, or (b) incurs 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.)

Line #	Entity/Person	Service/Description	Billing/Compensation	Month	Cost	Amount Paid	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 flow account and under no circumstances should any amount be claimed for personal services in an account other than flow. If additional space is needed, use the Facilities and Equipment Tab.

Line #	1	2	3	4	5	6	7	8	9	10	11	12
6.1	Sole Owner - Name, Address	Owner Name	Owner Title	% Time Devoted	Salary	Employee Benefits	Payroll Taxes	Workers Comp	Gr. Life/Health Ins.	Other	Total	Total
6.2												
6.3												
6.4												
6.5												
6.6												
6.7												
6.8												
6.9												
6.10												

Five Highest Paid Salaries

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

Line #	1	2	3	4	5	6	7	8	9	10	11	12	13	14
7.1	Name	Title	% Time Devoted - Administration	% Time Devoted - Front Operations, Maintenance, and Security	% Time Devoted - Medical Services	% Time Devoted - Other	Total Time Devoted (100%)	Salary	Employee Benefits	Payroll Taxes	Workers Comp	Gr. Life/Health Ins.	Other	Total
7.2	JOHN DOE							\$100,000	\$10,000	\$10,000	\$10,000	\$10,000	\$10,000	\$150,000
7.3	JANE DOE							\$90,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,000	\$137,000
7.4	ABC COMPANY							\$80,000	\$8,000	\$8,000	\$8,000	\$8,000	\$8,000	\$122,000
7.5	DEF COMPANY							\$70,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$108,000
7.6	GHI COMPANY							\$60,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$90,000

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.

Line #	Account #	Description	Reported Amount	Destination
8.1	1000.0	Income		
8.2	1000.0	Income		
8.3	1000.0	Income		
8.4	1000.0	Income		
8.5	1000.0	Income		
8.6	1000.0	Income		
8.7	1000.0	Income		
8.8	1000.0	Income		
8.9	1000.0	Income		
8.10	1000.0	Income		
8.11	1000.0	Income		
8.12	1000.0	Income		
8.13	1000.0	Income		
8.14	1000.0	Income		
8.15	1000.0	Income		
8.16	1000.0	Income		
8.17	1000.0	Income		
8.18	1000.0	Income		
8.19	1000.0	Income		
8.20	1000.0	Income		
8.21	1000.0	Income		
8.22	1000.0	Income		
8.23	1000.0	Income		
8.24	1000.0	Income		
8.25	1000.0	Income		
8.26	1000.0	Income		
8.27	1000.0	Income		
8.28	1000.0	Income		
8.29	1000.0	Income		
8.30	1000.0	Income		
8.31	1000.0	Income		
8.32	1000.0	Income		
8.33	1000.0	Income		
8.34	1000.0	Income		
8.35	1000.0	Income		
8.36	1000.0	Income		
8.37	1000.0	Income		
8.38	1000.0	Income		
8.39	1000.0	Income		
8.40	1000.0	Income		
8.41	1000.0	Income		
8.42	1000.0	Income		
8.43	1000.0	Income		
8.44	1000.0	Income		
8.45	1000.0	Income		
8.46	1000.0	Income		
8.47	1000.0	Income		
8.48	1000.0	Income		
8.49	1000.0	Income		
8.50	1000.0	Income		
8.51	1000.0	Income		
8.52	1000.0	Income		
8.53	1000.0	Income		
8.54	1000.0	Income		
8.55	1000.0	Income		
8.56	1000.0	Income		
8.57	1000.0	Income		
8.58	1000.0	Income		
8.59	1000.0	Income		
8.60	1000.0	Income		
8.61	1000.0	Income		
8.62	1000.0	Income		
8.63	1000.0	Income		
8.64	1000.0	Income		
8.65	1000.0	Income		
8.66	1000.0	Income		
8.67	1000.0	Income		
8.68	1000.0	Income		
8.69	1000.0	Income		
8.70	1000.0	Income		
8.71	1000.0	Income		
8.72	1000.0	Income		
8.73	1000.0	Income		
8.74	1000.0	Income		
8.75	1000.0	Income		
8.76	1000.0	Income		
8.77	1000.0	Income		
8.78	1000.0	Income		
8.79	1000.0	Income		
8.80	1000.0	Income		
8.81	1000.0	Income		
8.82	1000.0	Income		
8.83	1000.0	Income		
8.84	1000.0	Income		
8.85	1000.0	Income		
8.86	1000.0	Income		
8.87	1000.0	Income		
8.88	1000.0	Income		
8.89	1000.0	Income		
8.90	1000.0	Income		
8.91	1000.0	Income		
8.92	1000.0	Income		
8.93	1000.0	Income		
8.94	1000.0	Income		
8.95	1000.0	Income		
8.96	1000.0	Income		
8.97	1000.0	Income		
8.98	1000.0	Income		
8.99	1000.0	Income		
8.100	1000.0	Income		
8.101	1000.0	Income		
8.102	1000.0	Income		
8.103	1000.0	Income		
8.104	1000.0	Income		
8.105	1000.0	Income		
8.106	1000.0	Income		
8.107	1000.0	Income		
8.108	1000.0	Income		
8.109	1000.0	Income		
8.110	1000.0	Income		
8.111	1000.0	Income		
8.112	1000.0	Income		
8.113	1000.0	Income		
8.114	1000.0	Income		
8.115	1000.0	Income		
8.116	1000.0	Income		
8.117	1000.0	Income		
8.118	1000.0	Income		
8.119	1000.0	Income		
8.120	1000.0	Income		
8.121	1000.0	Income		
8.122	1000.0	Income		
8.123	1000.0	Income		
8.124	1000.0	Income		
8.125	1000.0	Income		
8.126	1000.0	Income		
8.127	1000.0	Income		
8.128	1000.0	Income		
8.129	1000.0	Income		
8.130	1000.0	Income		
8.131	1000.0	Income		
8.132	1000.0	Income		
8.133	1000.0	Income		
8.134	1000.0	Income		
8.135	1000.0	Income		
8.136	1000.0	Income		
8.137	1000.0	Income		
8.138	1000.0	Income		
8.139	1000.0	Income		
8.140	1000.0	Income		
8.141	1000.0	Income		
8.142	1000.0	Income		
8.143	1000.0	Income		
8.144	1000.0	Income		
8.145	1000.0	Income		
8.146	1000.0	Income		
8.147	1000.0	Income		
8.148	1000.0	Income		
8.149	1000.0	Income		
8.150	1000.0	Income		
8.151	1000.0	Income		
8.152	1000.0	Income		
8.153	1000.0	Income		
8.154	1000.0	Income		
8.155	1000.0	Income		
8.156	1000.0	Income		
8.157	1000.0	Income		
8.158	1000.0	Income		
8.159	1000.0	Income		
8.160	1000.0	Income		
8.161	1000.0	Income		
8.162	1000.0	Income		
8.163	1000.0	Income		
8.164	1000.0	Income		
8.165	1000.0	Income		
8.166	1000.0	Income		
8.167	1000.0	Income		
8.168	1000.0	Income		
8.169	1000.0	Income		
8.170	1000.0	Income		
8.171	1000.0	Income		
8.172	1000.0	Income		
8.173	1000.0	Income		
8.174	1000.0	Income		
8.175	1000.0	Income		
8.176	1000.0	Income		
8.177	1000.0	Income		
8.178	1000.0	Income		
8.179	1000.0	Income		
8.180	1000.0	Income		
8.181	1000.0	Income		
8.182	1000.0	Income		
8.183	1000.0	Income		
8.184	1000.0	Income		
8.185	1000.0	Income		
8.186	1000.0	Income		
8.187	1000.0	Income		
8.188	1000.0	Income		
8.189	1000.0	Income		
8.190	1000.0	Income		
8.191	1000.0	Income		
8.192	1000.0	Income		
8.193	1000.0	Income		
8.194	1000.0	Income		
8.195	1000.0	Income		
8.196	1000.0	Income		
8.197	1000.0	Income		
8.198	1000.0	Income		
8.199	1000.0	Income		
8.200	1000.0	Income		
8.201	1000.0	Income		
8.202	1000.0	Income		
8.203	1000.0	Income		
8.204	1000.0	Income		
8.205	1000.0	Income		
8.206	1000.0	Income		
8.207	1000.0	Income		
8.208	1000.0	Income		
8.209	1000.0	Income		
8.210	1000.0	Income		
8.211	1000.0	Income		
8.212	1000.0	Income		
8.213	1000.0	Income		
8.214	1000.0	Income		
8.215	1000.0	Income		
8.216	1000.0			

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 qualifying related residents. Claimed amounts include original, sale, written-off, damaged, and fully depreciated assets. If the realty company owns fixed assets of other nature, non-residential care programs, such as an adult day care program, the related fixed asset expenses must be reported as disclosed on this schedule in column "Non-Allowable Depreciation Expense". The allocation methodology for allocating fixed asset expenses must be reported in the business and depreciation schedule.

Table 1	1	2	3	4	5	6	7	8
Line #	Description	Allowable Cost Basis Beginning Balance	Claimed Additions	Claimed Dispositions	Allowable Cost Basis Ending Balance	Depreciation %	Depreciation Expense Reported on Financial Statements	Claimed WCD & B&B Depreciation Expense or Add-Backs
1.1	Land WCD-2	113,881			113,881			
1.2	Building WCD-2	227,415			227,415		5,798	5,798
1.3	Depreciation WCD-2					1.00%		
1.4	Equipment WCD-2					10.00%		
1.5	Software/Other Use Assets WCD-2					20.00%		
100	Total Claimed Fixed Asset Depreciation Expense	341,296			341,296		5,798	5,798

Claimed Other Fixed Asset Expenses

Table 2	Description	£
Line #		Claimed Fixed Asset Expenses - Realty Company (HCF-2 H4)
2.1	Long-Term Interest Expense *	
2.2	MA Corporate Excess Tax - Non-income Provision	
2.3	Building Insurance	0
2.4	Real Estate Taxes	17,467
2.5	Deceased Property Taxes	0
2.6	Other **	0
2.7	Total Recoverable Fixed Asset Income	
200	Total Claimed Fixed Asset Other Expenses	17,467

Total Claimed Fixed Asset Expenses

Table 3	1		
Line #	Description	Amount	
300	Total Claimed Fixed Asset Expenses	27,346	A/C # 9502.1

Detail of Other Operating Expenses A/C # 9562.2

Table 4	1	2	3
Line #	Description Expense	Amount	Category Amount
4.1	Insurance Expense		
4.2			
4.3			
4.4			
4.5			
400	Total Other Operating Expenses		

Part IV: Facility Specific Realty Company Mortgages and Notes Payable

SCHEDULE Mortgages & Notes

Supplemental Note 1: Report of 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 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	Amortization of Mortgage Acquisition Costs	Beginning Loan Balance - Dec 31	Beginning Balance - New Loans	Principal Payments	Pay Off Amount	Pay Off Date	Ending Loan Balance - Dec 31	Interest Rate %	Interest Expense (B)	Period Expense (C)	Total Fixed Interest (Amortization, Interest and Period Expense) (B + (C) + D)	
1.1	Mortgage	US Bank - 1000000 - 1000000000	Yes																	
1.2																				
1.3																				
1.4																				
1.5																				
1.6																				
1.7																				
1.8																				
100	TOTALS								0	0										
Equals form of A/C, B/C																Equals A/C + B/C + C				

Equity Sum of A/C # 1400.0, 1401.0, and 1402.0

Table 2	1	2	3	4	5	6	7	8	9
Line #	Lender Name	Related Party Select Yes/No	Beginning Balance Dec 31	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								

Equity Sum of A/C # 2000.0, 2001.0, 2002.0, and 2003.0

Equity A/C # 9562.2