

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	55-08711
1.2	Provider ID/MMIS ID	
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2022
1.4	Name of Facility	Joseph's Abbey Resident Care Facility, Inc.
1.5	Street Address	167 North Spencer Rd.
1.6	City	Spencer
1.7	Zip	01562
1.8	Telephone	508-885-8700
1.9	Federal Employer Identification Number	02-0801237
1.10	Responsible Person's Name	Brother Thomas Langenfeld
1.11	Responsible Person's Email	brthomasocso@yahoo.com
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	Officer
1.13	List Name of Person to Receive Rate Notifications	Brother Thomas Langenfeld
1.14	List Email of Person to Receive Rate Notifications	brthomasocso@yahoo.com
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.	12
1.19	Enter the facility's constructed bed capacity.	12
1.20	Has there been a change in licensed beds during the year? If yes, complete Bed License Information Table 1B in the adjacent table.	No
1.21	Date of purchase by current owner (MM/DD/YYYY)	3/12/2004
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.	No
1.32	Did you report any accrued expenses incurred in periods other than the current cost report period? If yes, you must report details of accrued expenses not related to the current cost report period in the Footnotes schedule.	No

Other Business Activities

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

Bed License Information

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

Contact Information		
Table 2		1
Line #	Description	
2.1	Contact Person Name	Brother Thomas Langenfeld
2.2	Residential Care Facility or Firm Name	Saint Joseph's Abbey Resident Care Facility, Inc.
2.3	Title	Treasurer
2.4	Street Address	167 North Spencer Rd.
2.5	City	Spencer
2.6	State	MA
2.7	Zip Code	01562
2.8	Phone Number	508-885-8700
2.9	Email Address	brthomasocso@yahoo.com

Preparer information		
Please use this section to provide contact information for a "Preparer," who is the authorizing person of this report, and is not the "Owner." If you are the sole authorized individual completing this report, please check the box below in Line 3.1.		
Table 3		1
Line #	Description	
3.1	I am the sole individual completing this cost report as an Owner, Partner, or Officer, and do not have a Preparer formally attesting to this information.	☒
3.2	Preparer Name	John P. Sannella
3.3	Preparer's Affiliation	Independent CPA
3.4	Nursing Facility or Firm Name	Sannella & Associates
3.5	Title	CPA
3.6	Street Address	4 Fairbanks Lane
3.7	City	North Reading
3.8	State	MA
3.9	Zip Code	01864
3.10	Phone Number	978-888-3112
3.11	Email Address	john.sannella@cpa.com
3.12	Type of Accounting Service Performed	Compilation

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : DISCLOSURES

IMPORTANT: This schedule is an integral part of the HCF-4 cost report. This schedule must be completed in its entirety. When completing this schedule the following definitions of direct and indirect beneficial owner apply: 1) A **direct owner** is defined as a person or entity having any rights or benefits of ownership and having an **interest of record** in any partnership, joint venture, corporation or other entity. 2) An **indirect beneficial owner** is defined as a person having any benefits or rights of ownership, either direct or indirect, through one or more intermediaries, through any understanding or relationship with a person or entity, **resulting in benefits of ownership which are not of record**. It is incumbent upon the owner to fully disclose such interest. This schedule **MUST** be completed in entirety.

Direct and Indirect Owners

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

Table 1	1	2	3	4	5
Line #	Owner Name (Last, First)	Address	Percent Ownership	Select Ownership Type	Select Direct or Indirect?
1.1	Cistercian Abbey of Spencer, Inc.	167 North Spencer Rd. Spencer, MA 01562	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	N/A				
2.2					
2.3					
2.4					
2.5					

Indebtedness

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

Table 3	1	2	3	4	5	6	7
Line #	Select type of debt	Select Payable From	Original Debt Amount	Date Issued	Balance 12/31	Select Payable To	List Owners Name
3.1	Other	Facility	885,438	3/1/2004	337,197	Owner	Cistercian Abbey of Spencer, Inc.
3.2							
3.3							
3.4							
3.5							

Related Party Transactions

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

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

Sole Proprietor, Partnership, or Corporate Information

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

Table 5	1	2	3	4	5	6	7	8	9	10	11	12
Line #	Select Owner, Partner, Officer	Owner Name	Owner Title	% Time Devoted	Salary	Employee Benefits	Payroll Taxes	Workers' Comp.	Gr. Life/Health Ins.	Draw	Other	Total
5.1	Officer	Vincent Rogers	President	As Needed	-	-	-	-	-	-	-	-
5.2	Officer	Thomas Langenfeld	Treasurer	As Needed	-	-	-	-	-	-	-	-
5.3	Officer	Aedaeus Hamilton	Director	As Needed	-	-	-	-	-	-	-	-
5.4	Officer	Aelred Marrah	Director	As Needed	-	-	-	-	-	-	-	-
5.5												-
5.6												-
5.7												-
5.8												-

Five Highest Paid Salaries

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

Table 6	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Line #	Name	Title	% Time Devoted - Administrative	% Time Devoted - Plant Operation, Maintenance, and Security	% Time Devoted - Medical Services	% Time Devoted - Other	Total Time (Must equal 100%)	Salary	Employee Benefits	Payroll Taxes	Workers' Comp.	Gr. Life/Health Ins.	Draw	Other	Total
6.1	Silana Sytara	Nurse Aide			100.00%		100.00%	49,416							65,902
6.2	Lorinda Kennedy	Nurse Aide			100.00%		100.00%	44,675		3,478	727	12,281			60,593
6.3	Gertrude Malesi	Nurse Aide			100.00%		100.00%	41,327		2,608	608	12,281		2,448	59,272
6.4	Saetha Thibault	Nurse Aide			100.00%		100.00%	45,039		3,445	635	35		1,902	51,056
6.5	Marian Germain	Nurse Aide			100.00%		100.00%	33,625		2,572	495				36,692

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	3,175
1.2	1030.0	Cash - On Hand	
1.3	1040.0	Temporary Investments	5,115
1.4	1050.0	Other Cash	
1.100	1010.0	Total Cash and Cash Equivalents	8,290
		Accounts Receivable	
1.5	1080.0	Private Patients	
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	46,919
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	46,919
		Loans Receivable	
1.10	1160.0	Loans Receivable from Officers/Owners	
1.11	1170.0	Loans Receivable from Employees	
1.12	1180.0	Loans Receivable from Affiliates/Related Parties	
1.13	1185.0	Other Loans Receivable	
1.300	1150.0	Total Loans Receivable	-
1.14	1190.0	Interest Receivable	
1.15	1210.0	Supply Inventory	
		Prepaid Expenses	
1.16	1270.0	Prepaid Interest	
1.17	1280.0	Prepaid Insurance	
1.18	1290.0	Prepaid Taxes	
1.19	1295.0	Capitalized Pre-Opening Costs *	
1.20	1300.0	Other Prepaid Expenses *	
1.400	1260.0	Subtotal Prepaid Expenses	-
1.21	1310.0	Other Current Assets	
100	1005.0	Total Current Assets	55,209

Fixed Assets

Do not report fully depreciated assets on this table.

Table 2			1	2	3
Line #	Account #	Description	Cost	Accumulated Depreciation	Net Book Value
2.1	1510.0	Land			0
2.2	1520.0	Building	1,351,141	(510,923.00)	840,218
2.3	1610.0	Building Improvements	236,735	(109,084.00)	127,651
2.4	1625.0	Leasehold Improvements			0
2.5	1630.0	Other Improvements			0
2.6	1650.0	Equipment	121,495	(85,568.00)	35,927
2.7	1700.0	Motor Vehicles	35,632	(35,632.00)	0
2.8	1710.0	Software/Limited Life Assets			0
200	1500.0	Total Non-Current Fixed Assets			1,003,796

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	1,059,005

Current Liabilities

Table 4			1
Line #	Account #	Description	Account Balance
		Accounts Payable	
4.1	2020.0	Trade Payables	4,077
4.2	2030.0	Accrued Expenses	4,500
4.3	2047.0	Due to Commonwealth of MA	
4.100	2010.0	Total Accounts Payable	8,577
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	18,960
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	18,960
		Accrued Salaries and Payroll Liabilities	
4.11	2190.0	Accrued Salaries	
4.12	2200.0	Accrued Payroll Tax Withheld	
4.13	2210.0	Accrued Employee Taxes Payable	
4.14	2220.0	Other Payroll Liabilities	3,080
4.300	2180.0	Total Accrued Salaries and Payroll Liabilities	3,080
		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	7,856
4.400	2250.0	Total Other Current Liabilities	7,856
400	2005.0	Total Current Liabilities	38,473

Long-Term Liabilities			
Table 5			1
Line #	Account #	Description	Account Balance
		Long-Term Liabilities (See Mortgages & Notes Schedule)	
5.1	2310.0	Mortgages *	337,197.00
5.2	2320.0	Other Long Term Debt *	
5.100	2300.0	Total Long-Term Liabilities	337,197
500	N/A	Total Liabilities	375,670

Net Worth			
Table 6			1
Line #	Account #	Description	Account Balance
		Proprietorship or Partnership Capital	
6.1	2520.0	Capital	
6.2	2530.0	Proprietor Drawings	
6.3	2540.0	Partner Drawings	
6.4	2550.0	Net Profit(Loss) - Current Year	
6.100	2510.0	Total Proprietorship or Partnership Capital	0
6.5	2620.0	Capital Stock	
6.6	2630.0	Additional Paid in Capital	
6.7	2640.0	Treasury Stock	
6.8	2650.0	Retained Earnings	683,335
6.200	2610.0	Total Corporation Capital	683,335
600	2000.0	Total Liabilities and Net Worth	1,059,005

Balance Sheet Check			
Table 7			1
Line #	Account #	Description	Account Balance
7.1	1000.0	Total Assets	1,059,005
7.2	2000.0	Total Liabilities and Net Worth	1,059,005
		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	9021.1	Private	84,200
1.2	9022.5	DFA	559,921
1.3	9022.6	MA DFA Patient Resource Income	118,648
1.4	9022.7	Non-MA DFA	
1.5	9023.1	MA Commission for the Blind	
1.6	9023.2	Via and Other Public	
1.7	9025.3	Adult Day Care Income	
1.8	9026.2	Other Non-Nursing Income	
1.9		COVID-Related Supplemental Payments	
Ancillary Services (Use Table 1A to Right to Reimburse Expenses)			
1.10	9033.1	Private	
1.11	9033.5	Medicaid (DMA)	
1.12	9032.7	Non-MA Medicaid	
1.13	9033.1	MA Commission for the Blind	
1.14	9033.2	Via & Other Public	
1.100	9030.0	Total Ancillary Services	0
Miscellaneous and Recoverable Income			
1.15	4150.0	Endowment & Other Nonrecoverable **	78,750
1.16	3140.0	Laundry Recoverable Income	
1.17	3150.0	Vending Machines Recoverable Income	
1.18	3160.0	Rest Order Recovery	
1.19	3170.0	Prior Year Retroactive Adjustment	
1.20	3180.0	Interest Income	10
1.21	3190.0	Operating Costs Recoverable	41
1.22	3196.0	Fixed Costs Recoverable	
1.200	3130.0	Total Miscellaneous and Recoverable Income	78,861
100	3000.0	Total Gross Income	843,625

Table 1A : Detail of Ancillary Services Expenses			
Report these amounts as non-allowable expenses on main schedule.			
Line #	Account #	Expense Classification	Amount
1A.1			
1A.2			
1A.3			
1A.4			
1A.5			
1A.100		Total Ancillary Expenses	0

Expenses				
Table 2				
Line #	Account #	Description	Reported Expenses	Total Allowable Expenses
Administrative Expenses				
2.1	4150.0	Administrative/Responsible Person Salaries	51,044	51,044
2.2	4125.1	Officer Salaries*		0
Other Expenses**				
2.3	4140.1	Clerical Salaries (Use Table 2A to Right to Reimburse Salaries)	2,022	2,022
2.4	4150.3	Electronic Data Processing, Payroll, and Bookkeeping Services	5,175	5,175
2.5	4160.3	Management Fees		0
2.6	4160.6	Management Consultants*		0
2.100	4130.1	Total Other Expenses	7,197	7,197
2.200	4100.0	Total Administrative Expenses	58,241	58,241
General Support & Expenses				
2.7	4120.1	Office Supplies	3,084	3,084
2.8	4261.5	Phone	1,279	1,279
2.90	4262.6	Directory Advertising		0
2.300	4260.0	Total Telephone Expenses	1,279	1,279
Travel Expenses***				
2.10	4275.1	Motor Vehicle Expenses*	2,280	2,280
2.11	4280.1	Conventions and Meetings		0
2.400	4270.5	Total Travel Expenses	2,280	2,280
Advertising Expenses				
2.12	4295.7	Help Wanted	711	711
2.13	4298.7	Promotional		0
2.500	4290.0	Total Advertising Expenses	711	711
Licenses and Fees Expenses				
2.14	4305.7	Licenses and Fees: Patient Care Related Portion	1,955	1,955
2.15	4302.0	Licenses and Fees: Not Related to Patient Care		0
2.600	4300.0	Total Licenses and Fees Expenses	1,955	1,955
Education and Training Expenses				
2.16	4306.1	Staff Development/Coordinator Salary		0
2.17	4306.2	Administration Training		0
2.18	4306.3	Other Required Education		0
2.19	4306.4	Job Related Education	896	896
2.700	4300.0	Total Education and Training Expenses	896	896
Employee Benefits				
2.20	4310.1	Employee Benefits - Pensions **		0
2.21	4310.2	Employee Benefits - Other	4,350	4,350
2.22	4339.2	Officer Profit Sharing and Other Benefits		0
2.800	4310.0	Total Employee Benefits	4,350	4,350
Accounting Expenses				
2.23	4320.1	Accounting- Appraisal Services		0
2.24	4360.3	Accounting- Other (Use Table 2B to Right to Reimburse Expenses)	4,500	4,500
2.900	4340.0	Total Accounting Expenses	4,500	4,500
Legal Expenses				
2.25	4380.3	Legal- Appal Service		0
2.26	4385.7	Legal- Division of Administrative Law Appeals - Filing Fees		0
2.27	4390.7	Other Legal		0
2.1000	4370.0	Total Legal Expenses	0	0
Payroll Taxes				
2.28	4411.1	Payroll Taxes - Other	27,724	27,724
2.29	4411.3	Payroll Taxes - Officers		0
2.1100	4400.0	Total Payroll Taxes	27,724	27,724
Insurance Expenses				
2.30	4428.2	Insurance- Department of Unemployment Assistance Claims (DUA) - A&G Portion		0
2.31	4431.7	Insurance- Malpractice and General Liability *	2,079	2,079
2.32	4432.7	Key Person Insurance		0
2.33	4436.8	Insurance- Building Improvements and Equipment	5,648	(5,648)
2.34	4424.1	Workers' Comp - Other	5,552	5,552
2.35	4424.2	Workers' Comp - Officers		0
2.36	4426.1	Group Life/Health - Other	30,821	30,821
2.37	4426.2	Group Life/Health - Officers		0
2.1200	4430.0	Total Insurance Expenses	50,104	(5,648)
2.38	4433.0	Interest on Late Payments, Penalties		0
2.39	4430.0	Interest on Working Capital		0
2.40	4435.0	Pre-Opening Expenses		0
2.41	4443.00	Other Operating Expenses (Use Table 2C to Right to Reimburse Expenses)	3,744	3,744
2.1300	4200.0	Total General Supplies and Expenses	106,579	94,931

Table 2A : Detail of Clerical Salaries				
Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1	Dr. Thomas Langenfeld	Bookkeeper	A/P, A/R, Payroll, Deposits	2,022
2A.2				
2A.3				
2A.4				
2A.5				
2A.6				
2A.7				
2A.8				
2A.9				
2A.10				
2A.11				
2A.12				
2A.13				
2A.14				
2A.15				
2A.16				
2A.100		Total Clerical Salaries		2,022

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	Brief Description of Service	
2B.1	Sannella & Associates	12/31/2023	4,500	A	Accrual for 2023 HCF-4 preparation	
2B.2						
2B.3						
2B.4						
2B.5						
2B.100		Sub-Total	4,500			
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.100		Sub-Total	0			
2B.300		Total Other Accounting	4,500			
Accounting Expense Codes						
A. HCF-4 Cost Report Prep		D. Personal Tax Prep		G. SEC Filings		
B. Medicare Cost Report Prep		E. Management Advisory Services		H. Other Allowable Accounting (Explain)		
C. Corporate Tax Prep		F. Certified Financial Statement Audit		I. Other Non-Allowable Accounting (Explain)		
Explain if using Code H and/or I:						

2.42	4510.8	Real Estate Taxes			0	0
2.43	4515.8	Personal Property Taxes*			0	0
2.44	4520.8	Interest Long-Term (See Mortgages & Notes Schedule)	26,518	(76,918)	0	0
2.45	4535.8	Rent - Real Property			0	0
2.46	4538.8	Other Rent (Use Table 2D to Right to Itemize Expenses)	0		0	0
2.47	4550.8	Depreciation - Building	33,778	(33,778)	0	0
2.48	4565.8	Depreciation - Building Improvements	14,207	(14,207)	0	0
2.49	4567.8	Depreciation - Leasehold Improvements			0	0
2.50	4568.8	Depreciation - Other Improvements			0	0
2.51	4570.8	Depreciation - Equipment	5,462	(5,462)	0	0
2.52	4583.8	Depreciation - Software/Limited Life Assets			0	0
2.1400	4540.0	Total Fixed Costs	80,365	(80,365)	0	0
Plant Operations, Maintenance & Security						
2.53	5105.3	Plant Operations, Maintenance & Security - Salaries			0	0
2.54	5110.3	Plant Operations, Maintenance & Security - Purchased Service	19,535		19,535	0
2.55	5115.5	Plant Operations, Maintenance & Security - Supplies and Expenses	5,217		5,217	0
2.56	5130.5	Plant Operations, Maintenance & Security - Utilities	40,821		40,821	0
2.57	5130.7	Plant Operations, Maintenance & Security - Repairs			0	0
2.1500	5100.0	Total Plant Operation, Maintenance & Security	70,573	0		70,573
Dietary						
2.58	5205.1	Dietary - Salaries			0	0
2.59	5220.5	Dietary - Food	26,996		26,996	0
2.60	5221.3	Dietary - Purchased Service	75,185		75,185	0
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			0	0
2.1600	5200.0	Total Dietary	102,181	0		102,181
Laundry						
2.64	5310.1	Laundry - Salaries			0	0
2.65	5320.1	Laundry - Purchased Service			0	0
2.66	5330.5	Laundry - Supplies and Expenses	610		610	0
2.67	5340.5	Laundry - Linen and Bedding			0	0
2.1700	5300.0	Total Laundry	610	0		610
Housekeeping						
2.68	5410.1	Housekeeping - Salaries			0	0
2.69	5415.1	Housekeeping - Purchased Service	46,322		46,322	0
2.70	5420.5	Housekeeping - Supplies and Expenses	5,259		5,259	0
2.1800	5400.0	Total Housekeeping	51,581	0		51,581
Nursing						
Registered Nurses						
2.71	6030.1	RN Salaries	117,139		117,139	0
2.73	6030.3	RN Purchased Service			0	0
Nurses Aides						
2.73	6041.1	LPN Salaries	6,984		6,984	0
2.74	6042.3	LPN Purchased Service			0	0
Nurses Aides						
2.75	6051.1	Nurses Aides Salaries	270,172		270,172	0
2.76	6052.4	Nurses Aides Purchased Service	4,403		4,403	0
2.1900	6000.0	Total Nursing	398,596	0		398,596
Medical Services						
2.77	6094.1	Quality Assurance Professional			0	0
2.78	6097.1	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	0
2.2000	6510.0	Total Physicians' Services	0	0		0
Medical Supplies & Drugs						
2.81	6520.5	Legend Drugs			0	0
2.82	6522.5	House Supplies Not Resold	14,216		14,216	0
2.83	6523.5	Resold to Private Patients			0	0
2.1100	6520.0	Total Medical Supply and Drugs	14,216	0		14,216
2.84	6530.0	Pharmacy Consultant			0	0
2.85	6540.0	Social Service Worker (Including Behavioral Health)			0	0
2.1200	6500.0	Total Medical Services	14,216	0		14,216
Restorative & Recreational Therapy						
Restorative Therapy						
2.86	7012.1	Indirect Restorative Therapy Salaries			0	0
2.87	7012.1	Direct Restorative Therapy Salaries			0	0
2.88	7012.2	Direct Restorative Therapy Benefits			0	0
2.89	7012.3	Indirect Restorative Therapy Consultants			0	0
2.90	7014.3	Direct Restorative Therapy Consultants			0	0
2.2300	7010.0	Total Restorative Therapy	0	0		0
Recreational Therapy						
2.91	7021.1	Recreational Therapy - Salaries	1,320		1,320	0
2.92	7022.3	Recreational Therapy - Purchased Service			0	0
2.93	7023.5	Recreational Therapy - Supplies and Expenses	1,002		1,002	0
2.94	7024.8	Recreational Therapy - Transportation			0	0
2.2400	7020.0	Total Recreational Therapy	2,322	0		2,322
2.2500	7000.0	Total Restorative & Recreational Therapy	2,322	0		2,322
Bad Accts - Taxes-Refunds-Day Care						
2.95	8010.0	Bad Accounts - Refunds, Taxes, Day Care			0	0
2.96	8015.0	Fines, Late Charges, and Penalties			0	0
2.97	8025.5	State & Federal Income Taxes			0	0
2.98	8027.7	Massachusetts Excise Tax			0	0
2.99	8030.0	Refunds and Allowances			0	0
2.101	8040.0	Adult Day Care Costs*			0	0
2.102	8065.0	Other Non-Nursing Costs*			0	0
2.3000	8000.0	Total Bad Accts - Taxes-Refunds-Day Care	0		0	0
200	4000.0	Total Expenses	879,526	0	(86,031)	793,513

A/C # 4000.0 A/C #9345.0 A/C # 9939.0

Table 2C: Detail of Other Operating Expenses		
Line #	Description	Amount
2C.1	Fixed-Tenure Fees	1,910
2C.3	Staff gfts.	162
2C.4	Loss on Disposal of Fixed Assets	1,668
2C.100	Total	3,740

Table 2D: Detail of Other Rent Expenses		
Line #	Description	Amount
2D.1	Equipment Rental	
2D.3		
2D.4		
2D.100	Total	0

Table 2E: Detail of Other Medical Services Expenses		
Line #	Description	Amount
2E.1		
2E.2		
2E.3		
2E.4		
2E.100	Total	0

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses		
Table 3		1
Line #	Account #	Description
8.1	9040.0	Total Reported Operating Expenses
8.2	9945.0	Less: Self-Disallowed Expenses
8.3	9939.0	Less: Automatically Disallowed Expenses
3.100	4001.1	Total Non-Allowable Expenses
8.4	9960.3	Allocated Administrative and General from Management Company (MCF-3)
8.5	9962.2	Other Operating Expense Add-Back from Realty Company (MCF-2 RV)
8.6	9963.3	Allocated Other Operating Expense Add-Back from Management Company
8.7	9961.3	Allocated Fixed Asset Expenses from Management Company (MCF-3)
8.8	9950.0	Claimed Fixed Asset Expenses from Claimed Fixed Assets Schedule
8.9	9952.8	Allocated Direct Variable (Dentist), Indirect Therapy & C&I Management Company Add-Back Expenses
3.110	9302.8	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 (inflating operating expenses)
300	4002.0	Total Allowable Operating Expenses Claimed

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

Footnote Legend

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

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

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

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : RESIDENT DAYS

Resident Days January 1 - March 31

Table 1	Account #		1
Line #		Payer Description	Reported Days
1.1	0210.5 & 0210.0	DTA Days	810
1.2	0212.5 & 0212.0	Massachusetts EAEDC	
1.3	0215.4 & 0215.0	Non-Massachusetts DTA	
1.4	0260.5 & 0260.0	MA Commission for the Blind	
1.5	0270.5 & 0270.0	Veterans Administration and Other Public **	
1.6	0290.5 & 0290.0	Private	50
100	0200.0	Total Resident Days January 1 - March 31	860

Resident Days April 1 - June 30

Table 2	Account #		1
Line #		Payer Description	Reported Days
2.1	0310.5 & 0310.0	DTA Days	819
2.2	0312.5 & 0312.0	Massachusetts EAEDC	
2.3	0315.4 & 0315.0	Non-Massachusetts DTA	
2.4	0360.5 & 0360.0	MA Commission for the Blind	
2.5	0370.5 & 0370.0	Veterans Administration and Other Public **	
2.6	0390.5 & 0390.0	Private	176
200	0300.0	Total Resident Days April 1 - June 30	995

Resident Days July 1 - September 30

Table 3	Account #		1
Line #		Payer Description	Reported Days
3.1	0410.5 & 0410.0	DTA Days	828
3.2	0412.5 & 0412.0	Massachusetts EAEDC	
3.3	0415.4 & 0415.0	Non-Massachusetts DTA	
3.4	0460.5 & 0460.0	MA Commission for the Blind	
3.5	0470.5 & 0470.0	Veterans Administration and Other Public **	
3.6	0490.5 & 0490.0	Private	103
300	0400.0	Total Resident Days July 1 - September 30	931

Resident Days October 1 - December 31			
Table 4	Account #		1
Line #		Payer Description	Reported Days
4.1	0510.5 & 0510.0	DTA Days	828
4.2	0512.5 & 0512.0	Massachusetts EAEDC	
4.3	0515.4 & 0515.0	Non-Massachusetts DTA	
4.4	0560.5 & 0560.0	MA Commission for the Blind	
4.5	0570.5 & 0570.0	Veterans Administration and Other Public **	
4.6	0590.5 & 0590.0	Private	92
400	0500.0	Total Resident Days October 1 - December 31	920

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	3,285
5.2	0612.5 & 0612.0	Massachusetts EAEDC	0
5.3	0615.4 & 0615.0	Non-Massachusetts DTA	0
5.4	0660.5 & 0660.0	MA Commission for the Blind	0
5.5	0670.5 & 0670.0	Veterans Administration and Other Public **	0
5.6	0690.5 & 0690.0	Private	421
500	0600.0	Total Annual Resident Days	3,706

Additional Patient Day Information			
Table 6		1	
Line #		Description	Reported Admission/Community Support Days
6.1	0140.0	Number of Admissions	4
6.2	0150.0	Number of Discharges	4
6.3	0170.0	Number of Public Community Support Admissions	4
6.4	0175.0	Number of Total Community Support Admissions	4
6.5	0180.0	Public Community Support Resident Days	3,285
6.6	0182.0	Private Community Support Resident Days	421
600	0185.0	Total Community Support Resident Days	3,706

Footnote Legend

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

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : CLAIMED FIXED ASSETS

Claimed Fixed Asset Expenses

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

Table 1		1	2	3	4	5	6	7	8	9
Line #	Description	Allowable Cost Basis Beginning Balance	Claimed Additions	Claimed Deletions	Allowable Cost Basis Ending Balance	Depreciation %	Depreciation HCF-4	Non-Allowable Depreciation Expense	Add-Backs from HCF-2 RH if applicable	Claimed Net Depreciation Expense
1.1	Land HCF-4				0					
1.2	Land HCF-2				0					
1.3	Building HCF-4	1,351,141			1,351,141		33,778			33,778
1.4	Building HCF-2				0				-	0
1.5	Improvements HCF-4	282,387		(45,652)	236,735	5.00%	14,207			14,207
1.6	Improvements HCF-2				0	5.00%			-	0
1.7	Equipment HCF-4	117,379	4,116		121,495	10.00%	5,462			5,462
1.8	Equipment HCF-2				0	10.00%			-	0
1.9	Software/Limited Life Assets HCF-4				0	33.33%				0
1.10	Software/Limited Life Assets HCF-2				0	33.33%			-	0
100	Total Claimed Fixed Asset Depreciation Expense	1,750,907	4,116	(45,652)	1,709,371		53,447	0	0	53,447

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 *	26,918	-	26,918
2.2	MA Corporate Excise Tax - Non-Income Portion		-	0
2.3	Building Insurance	5,648	-	5,648
2.4	Real Estate Taxes		-	0
2.5	Personal Property Taxes		-	0
2.6	Other Claimed Fixed Assets**		-	0
200	Total Claimed Fixed Asset Other Expenses	32,566	0	32,566

Total Claimed Fixed Asset Expenses			
Table 3		1	
Line #	Description	Total	
300	Total Fixed Assets Expenses Claimed	86,013	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)	2004
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?		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?		Refer to regulation 101 CMR 204.08(1)(a)	
6.3	If yes to the above question(s), provide the date the facility or major additions became operational. (MM/DD/YYYY)		Refer to regulation 101 CMR 204.08(1)(a)	
6.4	Did your facility file a petition with CHIA for an administrative adjustment for substantial capital expenditures during the year?		Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.5	If yes to question 6.4, provide the date of the petition. (MM/DD/YYYY)		Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.6	Were the substantial capital expenditures subject to a Determination of Need (DON) approval by the Department of Public Health (DPH)? If yes, complete DON Schedule below.		Refer to regulation 101 CMR 204.08(2)(a) 1.	
6.7	If yes to question 6.6, list expenditures.	Equipment	Improvements	Limited Life Assets

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

Footnote Legend

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

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

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : MORTGAGES AND NOTES

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

Mortgages and Notes Supporting Fixed Assets																				
Table 1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Line #	Select Type of Notes Payable	Lender Name	Related Party Yes/No Selection	Date Mortgage Acquired	Due Date	Number of Months Amortized	Monthly Payments	Original Loan Amount	Mortgage Acquisition Costs	Amortization of Mortgage Acquisition Costs	Beginning Loan Balance: Jan 1	Beginning Balance - New Loans	Principal Payments	Pay Off Amount	Pay Off Date	Ending Loan Balance: Dec 31	Interest Rate %	Interest Expense	Period Expenses	Total Fixed Interest (Amortization, Interest and Period Expenses)
1.1	Mortgage	Cistercian Abbey of Spencer, Inc.	Yes	3/1/2004	3/1/2029	300	6,471	885,438			387,937		(50,740)			337,197	7.38%	26,918		26,918
1.2																-				-
1.3																-				-
1.4																-				-
1.5																-				-
1.6																-				-
1.7																-				-
1.8																-				-
100	TOTALS								-	-						337,197		26,918	-	26,918

(A) (B) (C) (A) + (B) + (C)
A/C # 4520.8

Working Capital Debt									
Table 2	1	2	3	4	5	6	7	8	9
Line #	Lender Name	Related Party Yes/No Selection	Beginning Balance: Jan 1	New Loan Amount	Start Date	Principal Payments	Ending Balance: Dec 31	Interest Rate %	Interest Expense
2.1							-		
2.2							-		
2.3							-		
2.4							-		
2.5							-		
2.6							-		
200	TOTALS						-		-

A/C # 2100.0 less 2160.0 A/C # 4430.0

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : WAGES AND BENEFITS

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

Table 1		1	2	3	4	5	6	7
Line #	Description	Number of FTE (Round to one decimal place)	Number of Staff (Round to one decimal place)	Total Hours (Round to one decimal place)	Total Salaries	Group Life/Health Benefits	Pensions	Other Benefits
1.1	Staff Development	00,000.0						
		7110.2	7210.2	7310.2	4306.1	7410.2	7510.2	7610.2
1.2	Maintenance Staff	00,000.0						
		7111.2	7211.2	7311.2	5105.1	7411.2	7511.2	7611.2
1.3	Dietary Staff	00,000.0						
		7112.2	7212.2	7312.2	5205.1	7412.2	7512.2	7612.2
1.4	Dietician	00,000.0						
		7113.2	7213.2	7313.2	5231.1	7413.2	7513.2	7613.2
1.5	Laundry Staff	00,000.0						
		7114.2	7214.2	7314.2	5310.1	7414.2	7514.2	7614.2
1.6	Housekeeping Staff	00,000.0						
		7115.2	7215.2	7315.2	5410.1	7415.2	7515.2	7615.2
1.7	Quality Assurance	00,000.0						
		7116.2	7216.2	7316.2	6504.1	7416.2	7516.2	7616.2
1.8	Community Support Coordinator	00,000.0						
		7119.2	7219.2	7319.2	6507.1	7419.2	7519.2	7619.2
1.9	Social Services Staff	00,000.0						
		7120.2	7220.2	7320.2	6540.0	7420.2	7520.2	7620.2
1.10	Restorative - Indirect Salaries	00,000.0						
		7121.2	7221.2	7321.2	7011.1	7421.2	7521.2	7621.2
1.11	Restorative - Direct Salaries	00,000.0						
		7122.2	7222.2	7322.2	7012.1	7422.2	7522.2	7622.2
1.12	Recreational Staff	00,000.0	1.0	52.0	1,320			
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,001.0	3.0	2045.0	51,044			
		7124.2	7224.2	7324.2	4110.1	7424.2	7524.2	7624.2
1.14	Officer	00,000.0						
		7125.2	7225.2	7325.2	4125.1	7425.2	7525.2	7625.2
1.15	Clerical Staff	00,000.1	1.0	144.0	2,022			
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	00,001.8	12.0	3713.0	129,489			
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	00,000.1	2.0	225.0	6,994			
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,006.2	20.0	12975.0	270,372	36,877	1,902	2,448
		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.

[illegible]

[illegible]

RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : CERTIFICATIONS

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

Table 1		1
1.1	Firm Name / Realty Company	Sannella & Associates
1.2	Preparer's Last Name	Sannella
1.3	Preparer's First Name	John
1.4	Preparer's Middle Name	P.
1.5	Title	CPA
1.6	Street Address	4 Fairbanks Lane
1.7	City	North Reading
1.8	State	MA
1.9	Zip Code	01864
1.10	Phone Number	978-888-3112
1.11	Email Address	John.sannella@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:	4/30/2024



Certification by Owner, Partner, or Officer

Table 2		1
2.1	Last Name	Langenfeld
2.2	First Name	Br. Thomas
2.3	Middle Name	
2.4	Title	Treasurer
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	4/30/2024

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RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE : Condensed Realty Company Cost Report (HCF-2 R/H)

The HCF-2 RW must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 6535.3 "Rent Expenses for Real Property". This schedule must be completed whenever rent is paid to an individual, partnership, realty trust or other entity whether affiliated or not with the residential care facility. The HCF-2 RW serves the dual purpose of being a report to the Center by the individual or business entity which owns the real property to accurately reflect the complete financial condition AND a claim for reimbursement.

Part I: Facility Specific Realty Company Information and Disclosures

Facility Information		
Table 1		
Item #	Description	1
1.1	Relay Company Name	
1.2	1199	
1.3	Relay Company Office #	
1.4	Balance Sheet Date	
1.5	Relay Company Address	
1.6	City	
1.7	Zip	
1.8	Telephone	

IMPORTANT: Tables 2 through 4 are an integral part of the HCF-6 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 owning** in its 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 **interest of owning** in 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
UNIT #	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 owner(s) listed in Table 2 own, directly or indirectly, an interest of 5% or more.

Table #	1	2	3	4	5
1500 F	Nursing and/or Rest Home	UPN	Name of Owner	Company Address	% Ownership
1.1					
1.2					
1.3					
1.4					
1.5					

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	Select Owner's Name
0.1							
0.2							
0.3							
0.4							

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 compensation. Attach an addendum if necessary.

Data required during year: (provide an explanation if necessary.)								
Table 1	1	2	3	4	5	6	7	8
100 F	Entity/Person	Entity/Services	Entity/Compensation	Mark up	Cost	Account Payable	Name of Owner	% Ownership
3.1								
3.2								
3.3								
3.4								
3.5								
3.6								

Proprietor, Partnership, or Corporate Information

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

[illegible]

Five Highest Paid Salaries

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

[illegible]

Part II: Condensed Facility Specific Realty Company Financial Information

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

[illegible]

Assets Equals Liabilities and Net Worth

