

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	5507294
1.2	Provider ID/MMIS ID	110063052/C
1.3	Balance Sheet Date (MM/DD/YYYY)	12/31/2023
1.4	Name of Facility	Winterhill
1.5	Street Address	24 Chester Street
1.6	City	Worcester
1.7	Zip	01605
1.8	Telephone	508-755-6404
1.9	Federal Employer Identification Number	04-2757148
1.10	Responsible Person's Name	William Lange
1.11	Responsible Person's Email	langeresthorne@charter.net
1.12	Responsible Person's Affiliation (Select from Dropdown Menu)	Officer
1.13	List Name of Person to Receive Rate Notifications	William Lange
1.14	List Email of Person to Receive Rate Notifications	langeresthorne@charter.net
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.	15
1.19	Enter the facility's constructed bed capacity.	15
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)	7/1/1985
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.	William Lange Real Estate
1.28	Does the Balance Sheet schedule include any capitalized leases reported as assets? If yes, report the lease payments as a liability and include the lease on the Mortgages & Notes schedule.	No
1.29	Does the Profit Loss schedule include any expenses that have not been paid and reported as accrued liabilities, such as pension costs or self-insured workers' compensation? If yes, the unpaid or unfunded portions must be reported in column 2 of the Profit Loss schedule as self-disallowed expenses.	No
1.30	Does the Profit Loss schedule include any expenses for services of non-paid workers (volunteers) as provided in 101 CMR 204.07(6)? If yes, provide details of amounts and account numbers in the Footnotes schedule.	No
1.31	Did you report any employee's salary in more than one expense account? If yes, explain methodology of cost-splitting the salary in the Footnotes schedule.	No
1.32	Did you report any accrued expenses incurred in periods other than the current cost report period? If yes, you must report details of accrued expenses not related to the current cost report period in the Footnotes schedule.	No

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

Bed License Information			
Table 1B	1	2	3
Line #	Date From	Date To	# of Beds
1B.1			
1B.2			
1B.3			

Contact Information		
Table 2		1
Line #	Description	
2.1	Contact Person Name	Kevin Culliton
2.2	Residential Care Facility or Firm Name	Kevin Culliton CPA
2.3	Title	CPA
2.4	Street Address	PO Box 56
2.5	City	Charlton
2.6	State	MA
2.7	Zip Code	01507
2.8	Phone Number	508-347-3495
2.9	Email Address	kevincullitoncpa@gmail.com

Preparer Information		
<i>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.</i>		
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	Kevin Culliton
3.3	Preparer's Affiliation	Independent
3.4	Nursing Facility or Firm Name	Winterhill
3.5	Title	CPA
3.6	Street Address	PO Box 56
3.7	City	Charlton
3.8	State	MA
3.9	Zip Code	01507
3.10	Phone Number	508-347-3495
3.11	Email Address	kevincullitoncpa@gmail.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	William Lange	38 Davis, Milbury, MA	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	VIN	Name of Owner	Company Address	% Ownership
2.1	Daltone	5507286	William Lange	451 Cambridge, Wore	100%
2.2					
2.3					
2.4					
2.5					

Indebtedness

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

Table 3	1	2	3	4	5	6	7
Line #	Select type of debt	Select Payable From	Original Debt Amount	Date Issued	Balance 12/31	Select Payable To	List Owners Name
3.1							
3.2							
3.3							
3.4							
3.5							

Related Party Transactions

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

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

Sole Proprietor, Partnership, or Corporate Information

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

Table 5	1	2	3	4	5	6	7	8	9	10	11	12
Line #	Select Owner, Partner, Officer	Owner Name	Owner Title	% Time Devoted	Salary	Employee Benefits	Payroll Taxes	Workers' Comp.	Gr. Life/Health Ins.	Draw	Other	Total
5.1	Owner	William Lange	President	100.00%	78,000		6,240					84,240
5.2												-
5.3												-
5.4												-
5.5												-
5.6												-
5.7												-
5.8												-

Five Highest Paid Salaries

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

Table 6	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Line #	Name	Title	% Time Devoted - Administrative	% Time Devoted- Plant Operation, Maintenance, and Security	% Time Devoted - Medical Services	% Time Devoted - Other	Total Time (Must equal 100%)	Salary	Employee Benefits	Payroll Taxes	Workers' Comp.	Gr. Life/Health Ins.	Draw	Other	Total
6.1	Carmen Torres	CSC			100.00%		100.00%	36,917		3,269					39,586
6.2	Gilevsha Garcia	Aide			100.00%		100.00%	27,380		2,464					29,844
6.3	Miquel Calderon	Aide			100.00%		100.00%	23,720		2,135					25,855
6.4	Anaella Peraba	Cook				100.00%	100.00%	23,016		2,071					25,087
6.5	Reana Toro	Cook				100.00%	100.00%	30,300		2,727					33,027

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	68,034
1.2	1030.0	Cash - On Hand	
1.3	1040.0	Temporary Investments	
1.4	1050.0	Other Cash	
1.100	1010.0	Total Cash and Cash Equivalents	68,034
		Accounts Receivable	
1.5	1080.0	Private Patients	
1.6	1100.2	Publicly-Aided - MA LV IV (Billed)	52,631
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	52,631
		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	114,825
1.300	1150.0	Total Loans Receivable	114,825
1.14	1190.0	Interest Receivable	
1.15	1210.0	Supply Inventory	1,685
		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	237,175

Fixed Assets

Do not report fully depreciated assets on this table.

Table 2			1	2	3
Line #	Account #	Description	Cost	Accumulated Depreciation	Net Book Value
2.1	1510.0	Land			0
2.2	1520.0	Building			0
2.3	1610.0	Building Improvements			0
2.4	1625.0	Leasehold Improvements			0
2.5	1630.0	Other Improvements			0
2.6	1650.0	Equipment	4,117		4,117
2.7	1700.0	Motor Vehicles	12,211	(5,163.00)	7,048
2.8	1710.0	Software/Limited Life Assets			0
200	1500.0	Total Non-Current Fixed Assets			11,165

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	248,340

Current Liabilities

Table 4			1
Line #	Account #	Description	Account Balance
		Accounts Payable	
4.1	2020.0	Trade Payables	
4.2	2030.0	Accrued Expenses	
4.3	2047.0	Due to Commonwealth of MA	456
4.100	2010.0	Total Accounts Payable	456
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	
4.12	2200.0	Accrued Payroll Tax Withheld	
4.13	2210.0	Accrued Employee Taxes Payable	
4.14	2220.0	Other Payroll Liabilities	3,025
4.300	2180.0	Total Accrued Salaries and Payroll Liabilities	3,025
		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	110,126
4.400	2250.0	Total Other Current Liabilities	110,126
400	2005.0	Total Current Liabilities	113,607

Long-Term Liabilities			
Table 5			1
Line #	Account #	Description	Account Balance
		Long-Term Liabilities (See Mortgages & Notes Schedule)	
5.1	2310.0	Mortgages *	
5.2	2320.0	Other Long Term Debt *	
5.100	2300.0	Total Long-Term Liabilities	0
500	N/A	Total Liabilities	113,607

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	23
6.6	2630.0	Additional Paid in Capital	
6.7	2640.0	Treasury Stock	
6.8	2650.0	Retained Earnings	134,710
6.200	2610.0	Total Corporation Capital	134,733
600	2000.0	Total Liabilities and Net Worth	248,340

Balance Sheet Check			
Table 7			1
Line #	Account #	Description	Account Balance
7.1	1000.0	Total Assets	248,340
7.2	2000.0	Total Liabilities and Net Worth	248,340
		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	
1.2	9022.5	DFA	578,184
1.3	9022.6	MA DFA Patient Resource Income	
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	9150.0	Endowment & Other Nonrecoverable **	
1.16	9140.0	Laundry Recoverable Income	
1.17	9150.0	Vending Machines Recoverable Income	
1.18	9160.0	Real Estate Recovery	
1.19	9170.0	Prior Year Retroactive Adjustment	
1.20	9180.0	Interest Income	
1.21	9190.0	Operating Costs Recoverable	
1.22	9196.0	Fixed Costs Recoverable	
1.200	9130.0	Total Miscellaneous and Recoverable Income	0
100	9000.0	Total Gross Income	578,184

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	4150.1	Administrative/Responsible Person Salaries	78,000	78,000
2.2	4125.1	Officer Salaries*		0
Other Expenses**				
2.3	4140.1	Clerical Salaries (Use Table 2A to Right to Reimburse Salaries)		0
2.4	4150.3	Electronic Data Processing, Payroll, and Bookkeeping Services	3,000	3,000
2.5	4160.3	Management Fees		0
2.6	4130.6	Management Consultants*		0
2.100	4130.1	Total Other Expenses	3,000	3,000
2.200	4100.0	Total Administrative Expenses	81,000	81,000
General Support & Expenses				
2.7	4250.1	Office Supplies	1,447	1,447
2.8	4261.5	Phone	1,590	1,590
2.90	4262.6	Directory Advertising		0
2.300	4260.0	Total Telephone Expenses	1,590	1,590
Travel Expenses**				
2.10	4275.1	Motor Vehicle Expenses*		0
2.11	4280.1	Conventions and Meetings		0
2.400	4270.1	Total Travel Expenses	0	0
Advertising Expenses				
2.12	4295.7	Help Wanted	2,774	2,774
2.13	4298.7	Promotional		0
2.500	4290.0	Total Advertising Expenses	2,774	2,774
Licenses and Dues Expenses				
2.14	4305.7	Licenses and Dues: Patient Care Related Portion	1,865	1,865
2.15	4302.0	Licenses and Dues: Not Related to Patient Care		0
2.600	4300.0	Total Licenses and Dues Expenses	1,865	1,865
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		0
2.700	4300.0	Total Education and Training Expenses	0	0
Employer Benefits				
2.20	4310.1	Employee Benefits - Pensions **		0
2.21	4310.2	Employee Benefits - Other		0
2.22	4339.2	Officer Profit Sharing and Other Benefits		0
2.800	4310.0	Total Employee Benefits	0	0
Accounting Expenses				
2.23	4320.1	Accounting- Appeal Services		0
2.24	4360.3	Accounting- Other (Use Table 2B to Right to Reimburse Expenses)	14,760	14,760
2.900	4340.0	Total Accounting Expenses	14,760	14,760
Legal Expenses				
2.25	4380.1	Legal- Appeal 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	30,764	30,764
2.29	4411.2	Payroll Taxes - Officers		0
2.1100	4400.0	Total Payroll Taxes	30,764	30,764
Insurance Expense				
2.30	4428.7	Insurance- Department of Unemployment Assistance Claims (DUAC) - A&G Portion		0
2.31	4431.7	Insurance- Malpractice and General Liability **	3,414	3,414
2.32	4432.7	Key Person Insurance		0
2.33	4590.8	Insurance- Building Improvements and Equipment		0
2.34	4424.1	Workers' Comp - Other	2,004	2,004
2.35	4424.2	Workers' Comp - Officers		0
2.36	4426.1	Group Life/Health - Other		0
2.37	4426.2	Group Life/Health - Officers		0
2.1200	4420.0	Total Insurance Expenses	5,418	5,418
2.38	4415.0	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)	0	0
1.1300	4200.0	Total General Supplies and Expenses	58,618	58,618

Line #	Employee Name	Job Title	Brief Job Description	Gross Salary
2A.1				
2A.2				
2A.3				
2A.4				
2A.5				
2A.6				
2A.7				
2A.8				
2A.9				
2A.10				
2A.11				
2A.12				
2A.13				
2A.14				
2A.15				
2A.16				
2A.100			Total Clerical Salaries	0

Note: Use Column 2 of the main expense schedule to disallow any disallowed salaries for clinical 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	kevin colliton	01/01/23, 12/31/23	14,760	A	prop cost reports	
2B.2						
2B.3						
2B.4						
2B.5						
2B.100		Sub-Total	14,760			
Part II: Employee's Responsibilities Only						
Line #	Employee Name	Job Title	Salary	Select Code	Description of Responsibilities	% of time
2B.6						
2B.7						
2B.8						
2B.9						
2B.200		Sub-Total	0			
2B.300		Total Other Accounting	14,760			

Accounting Expense Codes			
A. HCF-4 Cost Report Prep	B. Personal Tax Prep	C. SEC Filings	
B. Medicare Cost Report Prep	D. Management Advisory Services	E. Other Allowable Accounting (Explain)	
C. Corporate Tax Prep	F. Certified Financial Statement Audit	G. 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*	42		(42)	0
2.44	4520.8	Interest Long-Term (See Mortgages & Notes Schedule)			0	0
2.45	4535.8	Rent - Real Property	25,000		(25,000)	0
2.46	4538.8	Other Rent (Use Table 2D to Right to Itemize Expenses)			0	0
2.47	4550.8	Depreciation - Building	0		0	0
2.48	4565.8	Depreciation - Building Improvements			0	0
2.49	4567.8	Depreciation - Leasehold Improvements			0	0
2.50	4568.8	Depreciation - Other Improvements			0	0
2.51	4570.8	Depreciation - Equipment			0	0
2.52	4585.8	Depreciation - Software/Limited Life Assets			0	0
2.1400	4540.0	Total Fixed Costs	25,042		(25,042)	0
Plant Operations, Maintenance & Security						
2.53	5105.1	Plant Operations, Maintenance & Security - Salaries				0
2.54	5110.1	Plant Operations, Maintenance & Security - Purchased Service	13,641			13,641
2.55	5115.1	Plant Operations, Maintenance & Security - Supplies and Expenses			4,307	4,307
2.56	5120.1	Plant Operations, Maintenance & Security - Utilities			24,033	24,033
2.57	5125.1	Plant Operations, Maintenance & Security - Deprec.			21,081	21,081
2.1500	5100.0	Total Plant Operations, Maintenance & Security			65,868	65,868
Dietary						
2.58	5205.1	Dietary - Salaries		79,763		79,763
2.59	5210.1	Dietary - Food		24,778		24,778
2.60	5215.1	Dietary - Purchased Service		700		700
2.61	5218.1	Dietician - Salary				0
2.62	5218.1	Dietician - Purchased Service				0
2.63	5219.1	Dietary - Supplies and Expenses				0
2.1600	5200.0	Total Dietary		105,241	0	105,241
Laundry						
2.64	5310.1	Laundry - Salaries				0
2.65	5310.1	Laundry - Purchased Service				0
2.66	5310.1	Laundry - Supplies and Expenses				0
2.67	5340.1	Laundry - Linen and Bedding				0
2.1700	5300.0	Total Laundry	0	0	0	0
Housekeeping						
2.68	5410.1	Housekeeping - Salaries		24,645		24,645
2.69	5415.1	Housekeeping - Purchased Service				0
2.70	5420.1	Housekeeping - Supplies and Expenses				0
2.1800	5400.0	Total Housekeeping		24,645	0	24,645
Nursing						
Registered Nurses						
2.71	6030.1	RN Salaries				0
2.72	6035.1	RN Purchased Service				0
LPNs						
2.73	6041.1	LPN Salaries				0
2.74	6042.1	LPN Purchased Service				0
Nurses Aides						
2.75	6051.1	Nurses Aides Salaries		114,085		114,085
2.76	6052.1	Nurses Aides Purchased Service		120		120
2.1900	6000.0	Total Nursing		114,205	0	114,205
Medical Services						
2.77	6504.1	Quality Assurance Professional				0
2.78	6507.1	Community Support Coordinator		36,317		36,317
Physician Services						
2.79	6514.1	Employee Physicals				0
2.80	6515.1	Other Medical Services Expenses (Use Table 2E to Right to Itemize Expenses)				0
2.2000	6510.0	Total Physician Services	0	0	0	0
Medical Supplies & Drugs						
2.81	6530.1	Legend Drugs			0	0
2.82	6532.1	Infuse Supplies Not Reused				0
2.83	6533.1	Resend to Private Patients				0
2.2100	6530.0	Total Medical Supplies and Drugs	0	0	0	0
2.84	6530.0	Pharmacy Consults				0
2.85	6540.0	Social Service Worker (Including Behavioral Health)				0
2.2200	6500.0	Total Medical Services	36,317	0	0	36,317
Restorative & Recreational Therapy						
Restorative Therapy						
2.86	7011.1	Indirect Restorative Therapy Salaries				0
2.87	7012.1	Direct Restorative Therapy Salaries				0
2.88	7012.2	Direct Restorative Therapy Benefits				0
2.89	7013.1	Indirect Restorative Therapy Consultants				0
2.90	7014.1	Direct Restorative Therapy Consultants				0
2.2300	7010.0	Total Restorative Therapy	0	0	0	0
Recreational Therapy						
2.91	7021.1	Recreational Therapy - Salaries				0
2.92	7021.1	Recreational Therapy - Purchased Service				0
2.93	7023.1	Recreational Therapy - Supplies and Expenses				0
2.94	7024.1	Recreational Therapy - Transportation				0
2.2400	7020.0	Total Recreational Therapy	0	0	0	0
2.2500	7000.0	Total Restorative & Recreational Therapy	0	0	0	0
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	8025.0	State & Federal Income Taxes			0	0
2.98	8027.0	Massachusetts Excise Tax			0	0
2.99	8030.0	Refunds and Allowances		11,895	(11,895)	0
2.101	8040.0	Adult Day Care Costs*			0	0
2.102	8050.0	Other Non-Housing Costs*			0	0
2.2600	8000.0	Total Bad Accts - Taxes-Refunds-Day Care		11,895	(11,895)	0
200	4000.0	Total Expenses		522,431	0	(36,737)
A/C # 4005.0 A/C #9345.0 A/C # 9335.0						

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

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

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

Reconciliation of Reported Operating Expenses to Allowable Operating Expenses		
Table 3		1
Line #	Account #	Description
8.1	9040.0	Total Reported Operating Expenses
8.2	9945.0	Less: Self-Disallowed Expenses
8.3	9939.0	Less: Automatically Disallowed Expenses
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 (Dedictary, 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	1,128
1.2	0212.5 & 0212.0	Massachusetts EAEDC	
1.3	0215.4 & 0215.0	Non-Massachusetts DTA	
1.4	0260.5 & 0260.0	MA Commission for the Blind	
1.5	0270.5 & 0270.0	Veterans Administration and Other Public **	
1.6	0290.5 & 0290.0	Private	
100	0200.0	Total Resident Days January 1 - March 31	1,128

Resident Days April 1 - June 30

Table 2	Account #		1
Line #		Payer Description	Reported Days
2.1	0310.5 & 0310.0	DTA Days	1,132
2.2	0312.5 & 0312.0	Massachusetts EAEDC	
2.3	0315.4 & 0315.0	Non-Massachusetts DTA	
2.4	0360.5 & 0360.0	MA Commission for the Blind	
2.5	0370.5 & 0370.0	Veterans Administration and Other Public **	
2.6	0390.5 & 0390.0	Private	
200	0300.0	Total Resident Days April 1 - June 30	1,132

Resident Days July 1 - September 30

Table 3	Account #		1
Line #		Payer Description	Reported Days
3.1	0410.5 & 0410.0	DTA Days	1,075
3.2	0412.5 & 0412.0	Massachusetts EAEDC	
3.3	0415.4 & 0415.0	Non-Massachusetts DTA	
3.4	0460.5 & 0460.0	MA Commission for the Blind	
3.5	0470.5 & 0470.0	Veterans Administration and Other Public **	
3.6	0490.5 & 0490.0	Private	
300	0400.0	Total Resident Days July 1 - September 30	1,075

Resident Days October 1 - December 31			
Table 4	Account #		1
Line #		Payer Description	Reported Days
4.1	0510.5 & 0510.0	DTA Days	995
4.2	0512.5 & 0512.0	Massachusetts EAEDC	
4.3	0515.4 & 0515.0	Non-Massachusetts DTA	
4.4	0560.5 & 0560.0	MA Commission for the Blind	
4.5	0570.5 & 0570.0	Veterans Administration and Other Public **	
4.6	0590.5 & 0590.0	Private	
400	0500.0	Total Resident Days October 1 - December 31	995

Annual Resident Days January 1-December 31			
Table 5	Account #		1
Line #		Payer Description	Total Reported Days
5.1	0610.5 & 0610.0	DTA Days	4,330
5.2	0612.5 & 0612.0	Massachusetts EAEDC	0
5.3	0615.4 & 0615.0	Non-Massachusetts DTA	0
5.4	0660.5 & 0660.0	MA Commission for the Blind	0
5.5	0670.5 & 0670.0	Veterans Administration and Other Public **	0
5.6	0690.5 & 0690.0	Private	0
500	0600.0	Total Annual Resident Days	4,330

Additional Patient Day Information			
Table 6		1	
Line #		Description	Reported Admission/Community Support Days
6.1	0140.0	Number of Admissions	8
6.2	0150.0	Number of Discharges	8
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	1,825
6.6	0182.0	Private Community Support Resident Days	
600	0185.0	Total Community Support Resident Days	1,825

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	3,000			3,000					
1.3	Building HCF-4				0					0
1.4	Building HCF-2	47,000			47,000				1,175	1,175
1.5	Improvements HCF-4	4,116			4,116	5.00%				0
1.6	Improvements HCF-2				0	5.00%			-	0
1.7	Equipment HCF-4	651			651	10.00%				0
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	54,767	0	0	54,767		0	0	1,175	1,175

Other Claimed Fixed Asset Expenses

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

Table 2		1	2	3
Line #	Description	Claimed Fixed Asset Expenses - Rest Home (HCF-4)	Claimed Fixed Asset Expenses - Realty Company (HCF-2 RH)	Total Other Claimed Fixed Asset Expenses
2.1	Long-Term Interest Claimed *		-	0
2.2	MA Corporate Excise Tax - Non-Income Portion		-	0
2.3	Building Insurance		-	0
2.4	Real Estate Taxes		5,975	5,975
2.5	Personal Property Taxes		42	42
2.6	Other Claimed Fixed Assets**		-	0
200	Total Claimed Fixed Asset Other Expenses	0	6,017	6,017

Total Claimed Fixed Asset Expenses			
Table 3		1	
Line #	Description	Total	
300	Total Fixed Assets Expenses Claimed	7,192	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)	1900.
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 FY2023 COST REPORT (HCF-4)

SCHEDULE : MORTGAGES AND NOTES

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

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

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	00,002.4	4.0	4985.0	79,763			
		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	00,000.7	2.0	1540.0	24,645			
		7115.2	7215.2	7315.2	5410.1	7415.2	7515.2	7615.2
1.7	Quality Assurance	00,000.0						
		7116.2	7216.2	7316.2	6504.1	7416.2	7516.2	7616.2
1.8	Community Support Coordinator	00,001.0	1.0	2080.0	36,317			
		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						
		7123.2	7223.2	7323.2	7021.1	7423.2	7523.2	7623.2
1.13	Administrator	00,001.0	1.0	2080.0	78,000			
		7124.2	7224.2	7324.2	4110.1	7424.2	7524.2	7624.2
1.14	Officer	00,000.0						
		7125.2	7225.2	7325.2	4125.1	7425.2	7525.2	7625.2
1.15	Clerical Staff	00,000.0						
		7126.2	7226.2	7326.2	4140.1	7426.2	7526.2	7626.2
1.16	RNs	00,000.0						
		7129.2	7229.2	7329.2	6030.1	7429.2	7529.2	7629.2
1.17	LPNs	00,000.0						
		7130.2	7230.2	7330.2	6041.1	7430.2	7530.2	7630.2
1.18	Nurses Aides	00,003.4	6.0	7130.0	114,085			
		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	Kevin Culliton CPA
1.2	Preparer's Last Name	Culliton
1.3	Preparer's First Name	Kevin Culliton
1.4	Preparer's Middle Name	NMI
1.5	Title	CPA
1.6	Street Address	PO Box 56
1.7	City	Charlton
1.8	State	MA
1.9	Zip Code	01507
1.10	Phone Number	508-347-3495
1.11	Email Address	kevin.cullitoncpa@gmail.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:	4/25/2024



Certification by Owner, Partner, or Officer

Table 2		1
2.1	Last Name	Lange
2.2	First Name	William
2.3	Middle Name	J
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	4/25/2024



RESIDENTIAL CARE FACILITY FY2023 COST REPORT (HCF-4)

SCHEDULE Condensed Realty Company Cost Report (HCF-2 RN)
The HCF-2 RN must be completed when expenses are included in the HCF-4 Profit or Loss Schedule account # 4335.6 "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 RN covers the fiscal year ending in reports to the Center by the individual or business entity which owns the real property to accurately reflect the complete financial condition HCF-2 cover the information.

Part I: Facility Specific Realty Company Information and Disclosures

Facility Information	
Table 1	Facility Name
1a	Facility Address
1b	Facility City/State/Zip
1c	Facility Phone Number
1d	Facility Fax Number
1e	Facility Email Address
1f	Facility Website
1g	Facility Type
1h	Facility License
1i	Facility Status

IMPORTANT: Tables 2 through 6 are an integral part of the HCF-4 cost report. These tables must be completed in its entirety. When completing these tables the following definitions of direct and indirect beneficial owner apply: 1) A direct owner is defined as a person or entity having any rights or benefits of ownership and having an interest of record in 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 understanding or relationship with a person or entity, resulting in benefits of ownership which are not of record. 3) A resident 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 1% 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	Owner Name (per 100%)	Address	Percent Ownership	Interest Ownership Type	Date of Report
2a	John Doe	1234 Main St, Anytown, NY 12345	100%	Direct	12/31/2023
2b					
2c					
2d					
2e					

Other General Facilities

List the name(s) of any other nursing and/or residential care facilities in which the owner listed in Table 2 own, directly or indirectly, an interest of 1% or more.

Table 3	Nursing and/or Residential Name	City	Name of Owner	Company Address	% Ownership
3a	ABC Nursing Home	Anytown, NY	John Doe	1234 Main St, Anytown, NY 12345	100%
3b					
3c					
3d					

Indebtedness

List any indebtedness (mortgages, debts, trust indentures, 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	Entity Type of Debt	Entity Payable Name	Original Debt Amount	Debt Period	Interest Rate	Debt Payable To	Debt Service Name
4a							
4b							
4c							
4d							
4e							

Related Party Transactions

Indicate any entity, person, or related party as defined in 45 CFR 204.10 and that (1) provides services, facilities, goods and/or supplies to this realty company, or (2) receives any salary, fee, or other compensation from this realty company. Indicate the amount paid by this realty company for the reporting year. (Attach an addendum if necessary.)

Table 5	Entity/Person	Amount/Value	Entity/Person	Amount/Value	City	Amount/Value	Name of Person	% Ownership
5a								
5b								
5c								
5d								
5e								

Proprietor, Partnership, or Corporate Information

This information must be reported for each of the highest amount of the amount and to disclose the salary and other compensation paid to owners as well as what amounts were charged. Sole proprietors should report the same amount as reported in the above account and under no circumstances should any amount be claimed for personal services in an account other than the above. If additional space is needed, use the Continuation and Explanation Table.

Table 6	Salaries/Owner/Partner/Officer	Owner Name	Owner Title	% Time Received	Salary	Employee Benefits	Agent Fees	Medical Comp.	Off. Life/Health Ins.	Other	Other	Total
6a	John Doe	John Doe	Owner	100%	\$100,000	\$10,000						\$110,000
6b												
6c												
6d												
6e												
6f												
6g												
6h												
6i												
6j												

Top Five Employees

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

Table 7	1	2	3	4	5	6	7	8	9	10	11	12	13	14
7a	Name	Title	% Time Received	% Time Received	% Time Received	% Time Received	Base Salary (per year)	Salary	Employee Benefits	Payroll Taxes	Medical Comp.	Off. Life/Health Ins.	Other	Total
7b							\$100,000	\$100,000	\$10,000					\$120,000
7c							\$80,000	\$80,000	\$8,000					\$96,000
7d							\$60,000	\$60,000	\$6,000					\$72,000
7e							\$40,000	\$40,000	\$4,000					\$48,000
7f							\$20,000	\$20,000	\$2,000					\$24,000

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.

[illegible]

Assets Equals Liabilities and Net Worth

[illegible]

Table 2		B	
Line #	Description	Claimed/Fund Asset Categories - Realty Company (HCP 3.06)	
2.1	State Tax Incentive/Refund *		
2.2	Mass Corporate Income Tax - Non-income portion		
2.3	Building Incentive		
2.4	Real Estate Taxes		5.30%
2.5	Personal Property Taxes		4%
2.6	Other **		
2.7	Other Receivable Fund Asset Income		
200	Total Claimed Fund Asset Other Expenses		5.82%

Table 9	1	
Line 9	Description	Amount
100	Total Claimed Fixed Asset Expenses	2,100

A/C 9 9502 1

Table 6		I	II	III	
Line 1	Enquirer Expense	Reported Expense	Amount left Enquirer's	Claimed Amount	
0.1	Interest & Payroll				0
0.2	Management Fee				0
0.3	Auto Expense				0
0.4	Ordinary Power	1,387			1,387
0.5					0
0.6	Total Other Operating Expenses	1,387	0	1,387	A/C #9602.2
		A/C #9606.0			

SCHEDULE - Mortgages & Notes

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

[illegible]

Table 3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84																	