STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES [EOHHS]
RATE SETTING UNIT

BM 64 SUPPLEMENTAL WORKSHEET CALENDAR YEAR 2017
{To be submitted with the BM-64 Cost Report}

Facility Name: ______________________________ Lic. No. ________________________

Signature and Declaration statements, (see Page 5 of the BM-64 Cost Report), apply to this information.

(1)

(a.) Has your facility requested an Advance Payment on its monthly remittance from EOHHS/DHS over the last 12 month period?

Yes____________ No ____________

If yes, please provide dates and amounts. ____________ $ ____________
____________ $ ____________

(b.) Has the facility (or related real estate company) paid its payroll, property, sales and use, and provider taxes on time during the past year? Yes ____________ No ____________

If no, please provide a schedule of delinquent payments, including the due date of the applicable tax payments and the payment date of the delinquent taxes.

(c.) Are there any tax amounts that are greater than three months delinquent?

Yes ____________ No ____________

If yes, please list vendor, amount and reason for non-payment.

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(d.) Has the facility (or related real estate company) been greater than thirty days delinquent on its mortgage during the past year?

Yes ____________ No ____________

If the delinquency has not been cleared as of the end of the calendar year, please provide a schedule of delinquent mortgage payments, including due dates and payment dates of delinquent payments.

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(2)

(a.) Please list the operating gains or (losses) for this calendar year and the preceding calendar year for the operating company (license holder).

	2017	2016
(a.) Operating gains or (losses)	$ ______________	$ ______________
(b.) Depreciation and amortization expense	$ ______________	$ ______________

(b.) Please list the total amount of depreciation expense and amortization expense for the facility for each calendar year.

(3)

Please list by age, accounts receivable and accounts payable at December 31, 2017 in the appropriate box.

TOTAL	0 to 30 days	31 to 90 days	91 to 180 days	Over 180 days
Accounts Receivable $__________________				
Accounts Payable $__________________				

If there is an amount listed as over 180 days for Accounts Payable, please list vendor, amount and reason for non-payment (attach additional schedule if necessary).

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(4)

Please complete the following schedule on liquidity:

		12/31/2017	12/31/2016
Cash		$________________	$________________
Receivables for resident services, net of allowances		$________________	$________________
Total liquid assets	(a)	$________________	$________________
Total accounts payable and accrued expenses due within 30 days	(b)	$________________	$________________
Ratio (a / b)		________________	________________

(5)

Compute your facility's working capital position for calendar years ending December 31, 2016 and 2017.

		2017	2016
Total current assets	(a)	$________________	$________________
Minus Total current liabilities	(b)	$________________	$________________
Working Capital (deficit)		$________________	$________________
Ratio (a / b)		________________	________________

(6)

(a.) Did the operating company receive audited financial statements for any period covering C/Y 2017?
_____________Yes   ____________ No

(b.) If yes, did the audited financial statement include a going concern statement?
_____________Yes   ____________ No

If yes, please attach a copy of the financial statement.

BM-64 Supplemental [Calendar Year 2017]

Signature and Declaration Page
Please Review This Page in Conjunction With the Complete Report
Before Signing and Submittting This Report

I hereby certify that this facility, the BM-64 Supplemental for which is being submitted, is duly licensed by the State of Rhode Island as a Nursing Facility.

I further declare and certify, under penalties of perjury, that the Labor Related Report, including any attached schedules, has been examined by me and to the best of my knowledge and belief is a true and complete statement of the information requested.

Penalties for misrepresentatioon or fraudulent acts involving this program are covered by both Section 1909(a) of the Social Security Act, and Sections 11-41-3 and 11-41-4 of the Rhode Island General Laws and other applicable statutes.

Name of Facility ______________________ Facility Lic. # ______________________

This is the Original Signature Page that pertains to the BM-64 Supplemental for Calendar Year 2017 that was submitted to the state by email, in electronic form, on ______________________ *mm/dd/yyyy*

Signature of Owner, Partner or Officer ______________________ Title ______________________ Date ______________________

(Print name of signatory listed above) ______________________

Signature of Preparer ______________________ Title ______________________ Date ______________________

Original signatures are required for this page. Do not use a stamp or only submit a Copy of this page

Submit Hardcopy to: EOHHS, Rate Setting Unit [Attn: Arthur Abraham], Virks Bldg. (Rm 432), 3 West Road, Cranston, RI 02920