

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF HEALTH & HUMAN SERVICES  
RATE SETTING UNIT  
HAZARD BUILDING, #74 WEST ROAD  
CRANSTON, RHODE ISLAND 02920  
REPORT FOR CALENDAR YEAR 2013

**INSTRUCTIONS FOR COMPLETION OF SCHEDULES OF BM-64**

The Schedules filed with the Cost Report must reflect activity for the calendar year. This report must be prepared in accordance with generally accepted accounting principles, and on the accrual basis of accounting. The BM-64 Cost Report should be typewritten or written in ink. Reports not properly completed as to all information requested or completed in pencil are not acceptable and will be returned to the provider.

Reproductions of this report are acceptable and will be allowed to be submitted provided they are in the same format and presented in the same context by page numbers.

Page 5 requires the original signature of an officer, owner or partner. Mechanically reproduced signatures, rubber stamps and copies of original signatures are not acceptable. **The signature of an administrator who is not an officer, owner or partner is not acceptable. Submissions by Not for Profit facilities should be signed by the President of the Board of Directors or the Director of Finance.**

**INSTRUCTIONS FOR COMPLETION OF SCHEDULES OF BM-64 (Cont'd)**

**Schedule 'A' – Adjustment of Trial Balance**

This schedule provides for the preparation of a trial balance of income and expense accounts taken from the facility's general ledger, and also provides for adjustments to these accounts prior to the preparation of Schedule 'B', Statement of Operation. Account titles should not be changed nor should account numbers not listed be added.

Nursing home facilities participating in the Nurse's Aide Training Competency Evaluation Program will be required to complete information on page 11 and 13, and to file form NA\_\_TRN (91), for payment.

**Columns 1, 2 and 3 – Salaries, Other, Total**

The amounts shown in these columns should be in agreement with the facility's general ledger.

Expenses per the general ledger should be listed on the appropriate lines in column 1 and column 2. Column 3 represents the sum total of columns 1 and 2.

**Column 4 – Adjustments**

Adjustments to recorded costs as reflected in column 4, are to be obtained from Schedule 'A-1'.

**Column 5 – Adjusted Trial Balance**

Adjust the amounts in column 3 by the increases or (decreases) entered in column 4 and extend the net balance to column 5. The total operating expenses and gross income as shown in column 5 must equal the total of column 3 plus or (minus) the total adjustment as shown in column 4.

## **Schedule 'A-1' – Adjustments**

This schedule is to be used to make adjustments to recorded costs to arrive at reimbursable costs and to provide an explanation for such adjustments. Attach supporting schedules to the BM-64 Cost Report. Example of adjustments are, but not limited to, the following:

- a. Reduction of costs for personal expenses.
- b. Reduction of costs for expenses not related to patient care.
- c. Reduction of costs for expenses in excess of maximum reimbursable limits.
- d. Entries necessary to reflect the accrual basis of accounting.
- e. Adjustments for various asset additions, if such adjustments were not made on the general ledger.
- f. Adjustment to remove Health Care Provider Assessment # 8470 in accordance with this form. The Health Care Provider Assessment is added to the rate assigned as calculated.
- g. Adjustment to remove costs for non-residents residing at the facility.
- h. Adjustment to remove costs relating to assisted living portion of facility, rental portion of facility or day care portion of facility.
- i. Adjustments to remove costs for depreciation, interest and lease expense as these expenses are calculated utilizing the Fair Rental Value System.
- j. Adjustments made to reclassify actual cost of payroll taxes, employee benefits and workers' compensation insurance between the Direct Labor and Other Operating Cost Centers.
- k. Adjustment to offset expenses due to receipt of related income, e.g. insurance proceeds, grant income, etc.
- l. Adjustments to remove costs as adjusted as per previous field/desk audits performed by the Rate Setting Unit, e.g. adjustments for family members.
- m. Adjustment to remove Non-Medicaid physical therapy expense, speech therapy expense, etc. The adjustment must also include applicable payroll taxes and fringe benefits.

### **NOTE:**

The total of adjustments as shown in Schedule 'A-1' must be in agreement with the total adjustments to income and expenses as shown in column 4, Schedule 'A'.

### **Schedule 'B' – Statement of Operations**

This schedule is to be used for a comparison of operations as reported for the year ended December 31, 2012 and operations for the year ended December 31, 2013. The amounts to be reported on this schedule for the current year are obtained from column 5 of Schedule 'A' and must reflect only those costs reimbursable under the Medicaid program.

### **Schedule 'B-1' – Analysis of Certain Line Items [Not Required for CY2013]**

This schedule is to be used to explain in detail certain line items as reported on Schedule 'B'. The total of the detail components of the individual account must agree with the total of this account as reported on Schedule 'B'.

### **Schedule 'B-2' – Interest and Indebtedness Schedule [Not Required for CY2013]**

This schedule is to be used to submit detail information on indebtedness and all interest as reported in Account No. 3452 on Schedule 'A', column 3. This information would apply, but not be limited to interest on mortgages, loans and notes payable, working capital loans, purchases from vendors and suppliers, property and payroll taxes, etc. The statement of any information such as date of loan, term, and interest rate as "various" is not acceptable.

### **Schedule 'B-3' – Depreciation Schedule [Not Required for CY2013]**

This schedule is to be used as a supporting statement to the depreciation claimed on Schedule 'A', column 3 and must be in agreement with that amount. Each provider is to submit an updated Depreciation Schedule recognizing that the Fair Rental system is in effect and that the Depreciation Schedule is the single source of information used by the department for initial updates of Fair Rental calculations.

The value of land is to be shown on this schedule although land is not a depreciable asset.

All assets are to be reported by year of acquisition, categorized according to a definite rate of depreciation, i.e. 10%, 20%, etc.

### **Schedule 'C' – Statement of Costs of Services from Related Organizations**

This schedule must be completed if question 5 is answered in the affirmative. Attach additional schedules or narrative if applicable.

## **Schedule 'D' – Payroll and Payroll Tax Information [Not Required for CY2013]**

This schedule is a summary of payroll and payroll taxes for the reporting year and declaration of salaries paid to certain individuals and is to be completed by all facilities. The title or job function must be specifically described, such as registered nurse, dietician, etc. Terms such as general administration, general supervision, etc. are not acceptable. The number of hours devoted weekly must also be specifically stated such as 20 hours, 40 hours, etc. General terms such as all or 100 percent are not acceptable.

### **CHECKLIST**

\_\_\_\_\_ Attach copies of all four quarters of 2013 Employer's Quarterly Federal Tax Return (Form 941), the Federal Unemployment Tax Return (Form 940) and all four State Unemployment Tax Returns (Form DES-TX-17).

\_\_\_\_\_ Attach a listing of all employees showing name, specific job description, such as office manager, bookkeeper, clerical, cook, dietary aide, registered nurse, etc., hourly rate (include hourly basis of salaried employees), total compensation paid per the individual W-2 Forms and dates of hire and/or termination for those individuals hired and/or terminated during the current reporting period. This listing must be totaled and be in agreement with the total of the four 941's as shown on the Schedule 'D'.

**If job description codes are utilized, a copy of the key code summary must be submitted.**

\_\_\_\_\_ Attach a listing of all consultants by name, job description, hourly rate of pay and total amount paid.

## **Schedule 'D' Statement of Total Hours Worked**

The statement of total hours should include only those hours, whether regular hours or overtime hours, actually worked and should reflect the hours in the beginning and ending payroll accrual. Hours compensated but not worked, such as vacation, sick, holiday hours, etc. should be excluded from the total hours.

### **Schedule 'E' – Balance Sheet**

This schedule is a statement of financial condition of the facility at the close of the reporting year and the prior year, and is to be submitted by all providers filing the BM-64.

**Please note that a balance sheet must be submitted for the operating company ( RI Department of Health license holder) and the affiliated realty company, if there are two entities associated with this facility. Please refer to questions 5 & 6 on page 3. A consolidated balance sheet for both entities is not acceptable.**

If the affiliated realty company is owned by an individual, and a balance sheet for this property is not available, a signed statement by that individual to that effect must be attached to the Cost Report.

### **BM-64 Supplemental Worksheet**

Each provider is required to complete the BM-64 Supplemental Worksheet information for the calendar year and submit this information with the BM-64 Cost Report. Please note that signature and declaration statements as listed on BM-64 Page 5 apply to this information.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
OFFICE OF HEALTH & HUMAN SERVICES  
RATE SETTING UNIT  
HAZARD BUILDING, #74 WEST ROAD  
CRANSTON, RHODE ISLAND 02920  
BM-64 COST REPORT FOR CALENDAR YEAR 2013

GENERAL INFORMATION

Name of Facility \_\_\_\_\_ D.O.H. License No. \_\_\_\_\_

Facility Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

Date Report Completed \_\_\_\_\_ By Whom \_\_\_\_\_ Phone \_\_\_\_\_

Name of Licensed Administrator \_\_\_\_\_ License No. \_\_\_\_\_

Name, Address and Phone Number of Accountant and/or Accounting Firm:  
\_\_\_\_\_  
\_\_\_\_\_

Accounting Basis: Calendar Year \_\_\_\_\_ or Fiscal Year Ending \_\_\_\_\_  
Method of Accounting: Cash \_\_\_\_\_ Accrual \_\_\_\_\_

**The BM-64 Cost Report must be completed on a calendar year basis utilizing the accrual method of accounting.**

1. a. Type of Ownership (check appropriate type)  
\_\_\_\_\_ Individual \_\_\_\_\_ Partnership  
\_\_\_\_\_ Non-profit Corporation \_\_\_\_\_ Proprietary Corp.  
\_\_\_\_\_ Other (Specify) \_\_\_\_\_  
  
b. Corporate/Partnership Name of Operating Company.  
\_\_\_\_\_  
  
c. List Names/Titles of all parties holding any interest in the facility. If any interest is held by a corporation, furnish the names of all parties holding any interest in that corporation. (Attach a separate schedule if necessary.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
2. Certification and Beds Licensed by RI Dept. of Health at 12/31/13.  
\_\_\_\_\_ Title XVIII Certified \_\_\_\_\_ Nursing Facility Beds  
\_\_\_\_\_ Residential/ \_\_\_\_\_ Other Beds(Specify)  
\_\_\_\_\_ Assisted Living Bed

- | <u>3. Census Information:</u>   | <u>Nursing Facility</u> |
|---|-------------------------|
| a. Licensed bed complement of facility at 12/31/13.   | _____                   |
| b. Number of Rhode Island State patient Days (Title XIX).   | _____                   |
| c. Number of Mass. State patient days (Title XIX).  | _____                   |
| d. Number of Medicare days (Title XVIII).   | _____                   |
| e. Number of private-paying patient days.   | _____                   |
| f. Number of Veteran Adm. patient days.   | _____                   |
| g. Number of Blue Cross patient days.   | _____                   |
| h. Number of Hospice Care days.   | _____                   |
| i. Number of Other Days.  | _____                   |
| j. Total Number of patient days care provided (3b+c+d+e+f+g+h+i).   | _____                   |
| k. Total Number of bed days available (Item 3a x 366)   | _____                   |
| l. Percentage of occupancy (Item 3j divided by 3k).<br>(Requires calculation if Line o is answered "yes")   | _____                   |
| m. Number of empty beds paid for to keep bed available for re-admission _____   |                         |
| n. Are these days included in census information on line j?    ___Yes    ___No  |                         |
| o. Was there a change in licensed bed capacity during year?    ___Yes    ___No  |                         |
| p. If answer to Line o is yes, please provide below the date(s) of approved change and the number of beds approved by Health Facilities Regulation. |                         |

_____	_____
_____	_____
_____	_____



4. Census Activity:

- a. Total number of patients in facility on January 1, 2013 (12:01 a.m.) \_\_\_\_\_
- b. Total number of admissions during calendar year 2013 \_\_\_\_\_
- c. Total of 4(a) plus 4 (b) \_\_\_\_\_
- d. Total number of patients in facility on December 31, 2013  
(11:59 pm) \_\_\_\_\_
- e. Total number of discharges during calendar year 2013 \_\_\_\_\_
- f. Total number of deaths during calendar year 2013 \_\_\_\_\_
- g. Total of 4 (d) plus 4 (e) plus 4 (f) \_\_\_\_\_

Note: Lines 4c and 4g must be in agreement.

- h. Number of Residential/Assisted Living Facility Beds \_\_\_\_\_

5. In the amount of costs reported in the BM-64 Cost Report, are any costs included which are a result of transactions with a related organization?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Schedule 'C' must be completed.

6. Is facility leased? \_\_\_\_\_ Yes \_\_\_\_\_ No

- a. If yes, state name and address of owner(s).

\_\_\_\_\_  
\_\_\_\_\_

- b. Is facility leased through an individual or individuals, a Realty, Holding or Service Company, a related party, or any such legal entity in which there is common ownership between the facility and said individual(s), Realty, Holding or Service Company?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If 6b is Yes, list the names of all affiliated companies/individuals with a 10 percent or more interest (direct or indirect) in said Realty, Holding or Service Company:

<u>Name of Affiliated Company/Individual</u>	<u>Percentage of Ownership</u>
_____	_____
_____	_____
_____	_____
_____	_____

7. What was your average daily room and board charge for private-paying patients in semi-private rooms during calendar year 2013?

Maximum \$ \_\_\_\_\_ Minimum \$ \_\_\_\_\_

8. Is facility participating in Title XVIII, Federal Medicare? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, furnish the following:

a. Name of Intermediary \_\_\_\_\_

b. Federal Medicare average per diem in 2013 for this facility \$ \_\_\_\_\_  
(Attach Schedule if necessary)

9. a. State Income Tax calendar or fiscal 2013 \$ \_\_\_\_\_  
Federal Income Tax calendar or fiscal 2013 \$ \_\_\_\_\_

b. Has State Income Tax and/or Federal Income Tax been reported as expense on Schedule 'B'?

\_\_\_\_\_ Yes \_\_\_\_\_ No

c. If yes, indicate page number, account number and amount included.

<u>Page Number</u>	<u>Account Number</u>	<u>Amount</u>
_____	_____	_____
_____	_____	_____

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

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

I further declare and certify, under penalties of perjury, that the BM-64 Cost 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 misrepresentation 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.**

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Signature of Owner, Partner or Officer See instructions.	Title	Date
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(Print name of signatory listed above)

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Signature of Preparer	Title	Date
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**(Original signatures are required. Do not use a stamp or submit a copy of this page)**

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>	<b>Salaries Column 1</b>	<b>Other Column 2</b>	<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
	<b><u>PASS THROUGH ITEMS</u></b>					
1451	Real Estate Taxes	XXXXXX				
1451A	Personal Property Taxes	XXXXXX				
1451B	Fire Tax	XXXXXX				
2512	Fuel	XXXXXX				
2513	Gas	XXXXXX				
2514	Electricity	XXXXXX				
5442	Insurance	XXXXXX				
	<b>Total</b>					
	Health Care Provider Assessment					
8470	Provider Assessment	XXXXXX				XXXXXX
	<b>Total</b>					
	<b><u>FAIR RENTAL VALUE SYSTEM</u></b>					
3452	All Interest	XXXXXX				XXXXXX
3453	Rent	XXXXXX				XXXXXX
3453A	Lease/Rental of Equipment	XXXXXX				XXXXXX
3454	Amortization of Leasehold Improvements	XXXXXX				XXXXXX
3455	Building Depreciation	XXXXXX				XXXXXX
3455A	Building Improvements Depreciation	XXXXXX				XXXXXX
3457	Equipment Depreciation	XXXXXX				XXXXXX
3466	Motor Vehicles Depreciation	XXXXXX				XXXXXX
	<b>Total</b>					

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>	<b>Salaries Column 1</b>	<b>Other Column 2</b>	<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
	<b><u>DIRECT LABOR</u></b>					
4431	Health Care Plan (Employer's Share)	XXXXXX				
4432	Other Employee Fringe Benefits	XXXXXX				
4440	Payroll Taxes	XXXXXX				
4442A	Insurance-Workers Compensation	XXXXXX				
4511	Maintenance Salaries		XXXXXX			
4521	Dietary Salaries		XXXXXX			
4524	Purchased Dietary Services	XXXXXX				
4531	Laundry Salaries		XXXXXX			
4538	Laundry Purchased Services	XXXXXX				
4541	Housekeeping Salaries		XXXXXX			
4548	Housekeeping Purchased Services	XXXXXX				
4600	Director of Nurses		XXXXXX			
4601	R.N. Salaries		XXXXXX			
4611	L.P.N. Salaries		XXXXXX			
4615A	Physical Therapist – Medicare					XXXXXX
4615B	Physical Therapist – R.I. Medicaid					
4615C	Physical Therapist-Private-Paying-Other					XXXXXX
4615D	Physical Therapist-Medicaid-Other States					XXXXXX
4621	Salaries-Aides and others		XXXXXX			
	<b>Subtotal</b>					

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

Acct. No.	Name	Salaries Column 1	Other Column 2	Total Column 3	Adjustments Column 4	Adjusted Trial Balance Column 5
	<b><u>DIRECT LABOR (Cont'd)</u></b>					
4622A	Purchased Services of RN	XXXXXX				
4622B	Purchased Services of LPN	XXXXXX				
4622C	Purchased Services of N.A.'s	XXXXXX				
4715A	Other Therapeutic Services-Medicare					XXXXXX
4715B	Other Therapeutic Services-RI Medicaid					
4715C	Other Therapeutic Services-Private Paying & Other					XXXXXX
4728A	Other Labor-Salaries, Fees					
6415	Medical Director Salary or Fees					
6711	Physician's Salaries or Fees					
6713	Social Worker Salary or Fees					
6751	Recreational Activity Salaries or Fees					
	<b>Total</b>					
	<b><u>OTHER OPERATING EXPENSES</u></b>					
5425	Office Supplies	XXXXXX				
5426	Communications	XXXXXX				
5427	Travel-Motor Vehicle	XXXXXX				
5428	Conventions, Meetings	XXXXXX				
5428A	Education & Seminars	XXXXXX				
5429	Advertising and Public Relations	XXXXXX				XXXXXX
5429A	Advertising, Help Wanted	XXXXXX				
5430	Licenses and Dues	XXXXXX				
5433	Home Office/Central Services	XXXXXX				
5443	State Franchise Tax	XXXXXX				

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>	<b>Salaries Column 1</b>	<b>Other Column 2</b>	<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
	<b><u>Other Operating Expenses (Cont'd)</u></b>					
5449	Miscellaneous	XXXXXX				
5515	Water and Sewerage	XXXXXX				
5516	Maintenance Supplies	XXXXXX				
5518	Maintenance Purchased Services & Repairs	XXXXXX				
5522	Raw Food	XXXXXX				
5529	Dietary Supplies	XXXXXX				
5532	Linens and Bedding Supplies	XXXXXX				
5539	Laundry Supplies	XXXXXX				
5549	Housekeeping Supplies	XXXXXX				
5629	Nursing Supplies	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX
5629A	- Medicare	XXXXXX				XXXXXX
5629B	- RI Medicaid	XXXXXX				
5629C	- Private Paying & Other	XXXXXX				XXXXXX
5629D	- Medicaid Other States	XXXXXX				XXXXXX
5629E	- House	XXXXXX				
5724	Pharmacy Supplies	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX
5724A	- Medicare	XXXXXX				XXXXXX
5724B	- RI Medicaid	XXXXXX				
5724C	- Private Paying & Other	XXXXXX				XXXXXX
5724D	- Medicaid-Other States	XXXXXX				XXXXXX

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>	<b>Salaries Column 1</b>	<b>Other Column 2</b>	<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
	<b><u>Other Operating Expenses (Cont'd)</u></b>					
5724E	Pharmacy Supplies – House	XXXXXXX				
5728	Other Expenses	XXXXXXX				
5758	Recreational Supplies	XXXXXXX				
5759	Other	XXXXXXX				
7411	Administrator					
7412	Officer/Owners					
7421	Other Administrative Salaries					
7431	Health Care Plan (Employers Share)	XXXXXXX				
7432	Other Employee Fringe Benefits	XXXXXXX				
7433	Home Office/Central Services	XXXXXXX				
7435	Computer Payroll / Data Proc. Charges	XXXXXXX				
7436	Accounting/Auditing Fees	XXXXXXX				
7437	Legal Services	XXXXXXX				
7440	Payroll Taxes	XXXXXXX				
7442	Insurance (Workers Compensation)	XXXXXXX				
7444A	Utilization Review Medicaid Title XIX	XXXXXXX				
7449A	Miscellaneous Management Related	XXXXXXX				
7523	Dietary Consultant					
7712	Pharmacists Salaries/Fees					
	<b>Total</b>					



SCHEDULE 'A'

ADJUSTMENT OF TRIAL BALANCE

Acct. No.	Name	Salaries Column 1	Other Column 2	Total Column 3	Adjustments Column 4	Adjusted Trial Balance Column 5
	<u>Nurse's Aide Training &amp;</u>					XXXXXXXX
	<u>Evaluation Program</u>					XXXXXXXX
	Salaries					XXXXXXXX
	Supplies/Materials	XXXXXX				XXXXXXXX
	Other					XXXXXXXX
	<b>Total</b>					XXXXXXXX
	<b>Total Operating Expenses</b>					

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>			<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
0300	<b><u>GROSS INCOME</u></b>					
0300A	Room & Board-Private Paying Patients	XXXXXX	XXXXXX			
0300B	Room & Board-Federal Medicare Patients	XXXXXX	XXXXXX			
0300C	Room & Board-State Medicaid Patients	XXXXXX	XXXXXX			
0300D	Room & Board-Veteran Patients	XXXXXX	XXXXXX			
0300E	Room & Board-Private Insurance	XXXXXX	XXXXXX			
0300F	Room & Board-Employee	XXXXXX	XXXXXX			
0300G	Room & Board – Hospice Patients	XXXXXX	XXXXXX			
0300H	Room & Board – Managed Care Patients	XXXXXX	XXXXXX			
0300I	Retrospective Adjustment	XXXXXX	XXXXXX			
0301	Sale of Drugs & Supplies	XXXXXX	XXXXXX			
0302	Laboratory Fee Income	XXXXXX	XXXXXX			
0303A	Physical Therapy-Federal Medicare	XXXXXX	XXXXXX			
0303B	Physical Therapy-Private Paying Patients	XXXXXX	XXXXXX			
0303C	Physical Therapy-Other Patients	XXXXXX	XXXXXX			
0303D	Other Therapeutic Services- Medicare	XXXXXX	XXXXXX			
0303E	Other Therapeutic Services-Private	XXXXXX	XXXXXX			
0303F	Other Therapeutic Services-Other	XXXXXX	XXXXXX			
0304	Utilization Review-Medicare	XXXXXX	XXXXXX			
0305	Laundry Income	XXXXXX	XXXXXX			
0306	Guests and Employee Meals	XXXXXX	XXXXXX			
0307	Vending Machine Income	XXXXXX	XXXXXX			

**SCHEDULE 'A'**

**ADJUSTMENT OF TRIAL BALANCE**

<b>Acct. No.</b>	<b>Name</b>			<b>Total Column 3</b>	<b>Adjustments Column 4</b>	<b>Adjusted Trial Balance Column 5</b>
	<b><u>GROSS INCOME (Continued)</u></b>					
0308	Income from Empty Beds	XXXXXX	XXXXXX			
0309	Rent Income	XXXXXX	XXXXXX			
0310	Interest Income	XXXXXX	XXXXXX			
0311	Ancillary Service Income	XXXXXX	XXXXXX			
0312	Meals on Wheels Program	XXXXXX	XXXXXX			
0313	Day Care Program	XXXXXX	XXXXXX			
0314	Other Income (Specify)	XXXXXX	XXXXXX			
		XXXXXX	XXXXXX			
0315	Nurse's Aide Training/Competency					
	Evaluation	XXXXXX	XXXXXX			
	<b>TOTAL GROSS INCOME</b>					

**ADJUSTMENTS**  
**EXPENSES**

ACCOUNT NO.	ACCOUNT CLASSIFICATION	AMOUNT INCREASED (DECREASED) SHOWN IN COL. 4 SCHEDULE 'A'	DESCRIPTION
	TOTAL EXPENSE ADJ.		



**SCHEDULE 'B'**

<b><u>STATEMENT OF OPERATIONS – CALENDAR YEARS</u></b>	<b><u>Dec. 31, 2013</u></b>	<b><u>Dec. 31, 2012</u></b>
<b><u>PASS THROUGH ITEMS COST CENTER</u></b>		
1451 Real Estate Taxes	_____	_____
1451A Personal Property Taxes	_____	_____
1451B Fire Tax	_____	_____
2512 Fuel	_____	_____
2513 Gas	_____	_____
2514 Electricity	_____	_____
5442 Insurance (Complete Schedule 'B-1')	_____	_____
<b>TOTAL</b>	_____	_____
<b><u>DIRECT LABOR COST CENTER</u></b>		
4431 Health Care Plan	_____	_____
4432 Other Employee Fringe Benefits (Complete Schedule 'B-1')	_____	_____
4440 Payroll Taxes (Employer's Share Only)	_____	_____
4442A Insurance-Worker's Compensation	_____	_____
4511 Maintenance Salaries	_____	_____
4521 Dietary Salaries	_____	_____
4524 Purchased Dietary Services	_____	_____
4531 Laundry Salaries	_____	_____
4538 Laundry Purchased Services	_____	_____
4541 Housekeeping Salaries	_____	_____
4548 Housekeeping Purchased Services	_____	_____
4600 Director of Nurses	_____	_____
4601 Salaries – RN	_____	_____
4611 Salaries – LPN	_____	_____
4615B Physical Therapist – Title XIX – Medicaid	_____	_____
4621 Salaries – Aides and Others	_____	_____
4622A Purchased Services of RN	_____	_____
4622B Purchased Services of LPN	_____	_____
4622C Purchased Services of N.A.'s	_____	_____
4715B Other Ther. Services-Title XIX-Medicaid (Sch. 'B-1')	_____	_____
4728A Other Labor-Salaries, Fees (Complete Sch. 'B-1')	_____	_____
6415 Medical Director	_____	_____
6711 Physicians' Salaries or Fees	_____	_____
6713 Social Worker Salary or Fees	_____	_____
6751 Recreational Activities Salaries	_____	_____
<b>TOTAL</b>	_____	_____

SCHEDULE 'B'

STATEMENT OF OPERATIONS-CALENDAR YEARS    Dec.31, 2013

Dec.31, 2012

OTHER OPERATING COST CENTER

5425	Office Supplies and Printing	_____	_____
5426	Communications (Telephone)	_____	_____
5427	Travel-Motor Vehicle	_____	_____
5428	Conventions, Meetings	_____	_____
5428A	Education and Seminars	_____	_____
5429A	Advertising – Help Wanted	_____	_____
5430	Licenses and Dues	_____	_____
5433	Home Office/Central Services	_____	_____
5443	State Franchise Tax	_____	_____
5449	Miscellaneous (Complete Schedule 'B-1')	_____	_____
5515	Water and Sewerage	_____	_____
5516	Maintenance Supplies	_____	_____
5518	Maintenance Purchased Services & Repairs	_____	_____
5522	Raw Food	_____	_____
5529	Dietary Supplies	_____	_____
5532	Linens and Bedding Supplies	_____	_____
5539	Laundry Supplies	_____	_____
5549	Housekeeping Supplies	_____	_____
5629B	Nursing Supplies – RI Medicaid	_____	_____
5629E	Nursing Supplies – House	_____	_____
5724B	Pharmacy Supplies – RI Medicaid	_____	_____
5724E	Pharmacy Supplies – House	_____	_____
5728	Other Expenses (Complete Schedule 'B-1')	_____	_____
5758	Recreational Supplies	_____	_____
5759	Other	_____	_____
7411	Administrator	_____	_____
7412	Officer/Owners	_____	_____
7421	Other Administrative Salaries	_____	_____
7431	Health Care Plan	_____	_____
7432	Other Employee Fringe Benefits (Complete Schedule 'B-1')	_____	_____
7433	Home Office/Central Services	_____	_____
7435	Computer Payroll/Data Processing Charges	_____	_____

**SCHEDULE 'B'**

<b><u>OTHER OPERATING COST CENTER</u></b> (continued)	<b>Dec. 31, 2013</b>	<b>Dec. 31, 2012</b>
7436 Accounting/Auditing Fees	_____	_____
7437 Legal Services (Complete Schedule 'B-1')	_____	_____
7440 Payroll Taxes	_____	_____
7442A Insurance (Workers' Compensation)	_____	_____
7444A Utilization Review – Medicaid – Title XIX	_____	_____
7449A Miscellaneous Management Related (Complete Schedule 'B-1')	_____	_____
7523 Dietary Consultant	_____	_____
7712 Pharmacists Salaries/Fees	_____	_____
<b>TOTAL</b>	_____	_____
<b>TOTAL EXPENSES</b>	<b>=====</b>	<b>=====</b>



**SCHEDULE 'B'**

**STATEMENT OF OPERATIONS – CALENDAR YEARS ENDING Dec. 31, 2013**

**Dec. 31, 2012**

**GROSS INCOME**

0300A	Room & Board – Private-Paying Patients	_____	_____
0300B	Room & Board – Federal Medicare Patients	_____	_____
0300C	Room & Board – State Medicaid Patients	_____	_____
0300D	Room & Board – Veteran Patients	_____	_____
0300E	Room & Board - Private Insurance	_____	_____
0300F	Room & Board – Employees	_____	_____
0300G	Room & Board - Hospice Patients	_____	_____
0300H	Room & Board - Managed Care	_____	_____
0300I	Retrospective Adjustment	_____	_____
0301	Sale of Drugs and Supplies	_____	_____
0302	Laboratory Fee Income	_____	_____
0303A	Physical Therapy – Federal Medicare	_____	_____
0303B	Physical Therapy – Private-Paying Patients	_____	_____
0303C	Physical Therapy – Other Patients	_____	_____
0303D	Other Therapeutic Services Income – Federal Medicare	_____	_____
0303E	Other Therapeutic Services Income – Private-Paying Patients	_____	_____
0303F	Other Therapeutic Services Income – Other Patients	_____	_____
0304	Utilization Review – Federal Medicare – Title XVIII	_____	_____
0305	Laundry Income	_____	_____
0306	Guests and Employee Meals	_____	_____
0307	Vending Machine Income	_____	_____
0308	Income from Empty Beds	_____	_____
0309	Rent Income	_____	_____
0310	Interest Income	_____	_____
0311	Ancillary Service Income	_____	_____
0312	Meals on Wheels Program	_____	_____
0313	Day Care Program	_____	_____
0314	Other Income (Specify)	_____	_____
		_____	_____
	<b>TOTAL GROSS INCOME</b>	<b>=====</b>	<b>=====</b>

**[Not Required for CY2013] SCHEDULE 'B-1'**

**ANALYSIS OF CERTAIN LINE ITEMS**

<u>Page</u>	<u>Account Number</u>	<u>Name</u>	<u>Explanation</u>	<u>Amount</u>
16	5442	Insurance:		
		<u>TYPE</u>		
		<u>Liability Insurance</u>		\$ _____
		<u>Malpractice Insurance</u> (Audited Premium)		_____
		<u>Property Insurance</u>		_____
		<u>Personal Needs Surety Bond</u>		_____
		<u>Other Bond/s</u>		_____
		<u>Motor Vehicle Insurance :</u>		
		1 <sup>st</sup> Auto _____ Adjust to allowable ( _____ )		_____
		2 <sup>nd</sup> Auto _____ Adjust to allowable ( _____ )		_____
		3 <sup>rd</sup> Auto _____ Adjust to allowable ( _____ )		_____
		<u>Mortgage Insurance Premium (MIP)</u>	\$ _____	
		Adjustment to Medicaid allowable principal	\$( _____ )	
		Allowable Mortgage Insurance Premium	\$ _____	_____
		Medicaid Allowable Principal _____		
		Medicaid Allowable Percentage _____		_____
		<b>TOTAL</b>		\$ _____
16, 17,	4432 & 7432	Other Employee Fringe (Include the total reported in the two accounts:)		
		<u>Pension</u> _____		\$ _____
		<u>Employee Physicals</u> _____		_____
		<u>Employee Parties</u> _____		_____
		<u>Life Insurance</u> _____		_____
		<u>Other</u> _____		_____
		<b>TOTAL</b>		\$ _____
16	4715B	Other Therapeutic Services – Title XIX – Medicaid:		
		_____		_____
		_____		_____
		<b>TOTAL</b>		\$ _____

**[Not Required for CY2013] SCHEDULE 'B-1'**

**ANALYSIS OF CERTAIN LINE ITEMS**  
**(CONT'D)**

<b><u>Page</u></b>	<b><u>Account No.</u></b>	<b><u>Name</u></b>	<b><u>Explanation</u></b>	<b><u>Amount</u></b>
16	4728A	Other Labor – Salaries, Fees:		
			_____	_____
			_____	_____
		<b>TOTAL</b>		<b>\$ _____</b>
17	5449	Miscellaneous	_____	\$ _____
			_____	_____
			_____	_____
		<b>TOTAL</b>		<b>\$ _____</b>
17	5728	Other Expenses:	_____	\$ _____
			_____	_____
			_____	_____
		<b>TOTAL</b>		<b>\$ _____</b>
18	7437	<u>Legal Services:</u>		
		<u>Vendor</u>	<u>Purpose / Detail</u>	<u>Amount</u>
		_____	_____	\$ _____
		_____	_____	_____
		_____	_____	_____
		<b>TOTAL</b>		<b>\$ _____</b>
18	7449A	Miscellaneous Management Related:		
			_____	\$ _____
			_____	_____
			_____	_____
		<b>TOTAL</b>		<b>\$ _____</b>

**[Not Required for CY2013] SCHEDULE 'B-2'**

**INTEREST AND INDEBTEDNESS SCHEDULE (TO BE COMPLETED IN DETAIL)**

<b>Date of Loan</b>	<b>Creditor</b>	<b>Original Principal</b>	<b>Principal <u>Jan. 1, 2013</u></b>	<b>Balance <u>Dec. 31, 2013</u></b>	<b>Term</b>	<b>Interest Rate</b>	<b>Purpose Of Borrowing</b>	<b>Interest Amount</b>

**[Not Required for CY2013] SCHEDULE 'B-3'**

**DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL)**

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/12	REMAINING BASE	RATE	METHOD	DEPR. CLAIMED
LAND		XXXXXX	XXXXXX		XXXXXX	XXXXXX	XXXX	XXXXXX	XXXXXX
BUILDING									
TOTAL BUILDING				XXXXXX			XXXX	XXXXXX	
BUILDING IMPROV.									
TOTAL BLDG. IMPR.				XXXXXX			XXXX	XXXXXX	
TOTAL BLDG. & BUILDING IMPROV.				XXXXXX			XXXX	XXXXXX	

**DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL) CONTINUED**

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/12	REMAINING BASE	RATE	METHOD	DEPR. CLAIMED
LEASEHOLD IMPROV.									
TOTAL LEASEHOLD IMPROVEMENTS				XXX			XXX	XXX	
EQUIPMENT									
TOTAL EQUIPMENT				XXXXXX			XXXX	XXXXXX	

[Not Required for CY2013] SCHEDULE 'B-3'

**DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL) CONTINUED**

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/12	REMAINING BASE	RATE	METHOD	DEPR. CLAIMED
MOTOR VEHICLES									
TOTAL MOTOR VEHICLES				XXXXXX			XXXX	XXXXXX	
TOTALS				XXXXXX			XXX	XXX	

**NOTE: TO BE USED IF ADDITIONAL SHEETS ARE NECESSARY**

**[Not Required for CY2013] SCHEDULE 'B-3'**

**DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL)**

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/12	REMAINING BASE	RATE	METHOD	DEPR. CLAIMED



**SCHEDULE 'C'**

**STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS**

A. Name, and percent of ownership in the related organization and costs incurred as a result of transactions with related organizations.

Name of Owner	Name or Related Organization	Percent of Ownership	Account No.	Item	Amount Excluding Profit
1.					
2.					
3.					
4.					
5.					
6.					

B. Facilities which share central purchasing, accounting, administration and other services with other facilities and/or enterprises **must attach to and submit with this BM-64 Report the following:**

1. A complete statement of operations of the centralized services for calendar year 2013.
2. A schedule, attaching narrative if applicable, detailing facilities and/or enterprises serviced and method of allocation of income and expense to facilitate and/or enterprises serviced.
3. Attach copies of all four quarters of 2013 Employer's Quarterly Federal Tax Return (Form 941). Also attach a listing of all employees showing name, job description, hourly rate and total compensation paid per the individual W-2 Forms, as well as the date of hire and/or termination, if in the current reporting period.

**STATEMENT OF OWNERS, OFFICERS/AND OR FAMILY MEMEBERS IN  
EMPLOYMENT ( FAMILY MEMBERS TO INCLUDE IN-LAWS)  
ATTACH ADDITIONAL SHEETS IF NECESSARY**

Name	Title or Job Function		

**STATEMENT OF ADMINISTRATORS/AND OR  
ASSISTANT ADMINISTRATORS  
(OTHER THAN OWNERS)**

Name	Title or Job Function		

Employees are paid \_\_\_\_\_ (indicate whether weekly or bi-weekly).

**SCHEDULE 'D'**

**STATEMENT OF TOTAL HOURS WORKED**

Hours compensated but not worked, vacation, sick, holiday, should not be included.

DEPARTMENT	Hours: 1/1/13 – 12/31/13	Hours :1/1/12 – 12/31/12
<b>Payroll Hours:</b>		
<b>Nursing:</b>		
D.N.S.		
R.N.'s (exclusive of D.N.S.)		
L.P.N.'s		
Med. Tech.		
Aides & Others		
<b>Total Nursing</b>		
<b>Purchased Service Hours:</b>		
R.N.'s		
L.P.N.'s		
Aides & Others		
<b>Total Purchased Services</b>		
<b>TOTAL ALL HOURS</b>		

Operating Company: \_\_\_\_\_

**SCHEDULE 'E'**

**BALANCE SHEET**

<b>ASSETS</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Current Assets</b>			
Cash in bank and on hand			
Investments			
Notes Receivable			
Other Receivable			
Accounts Receivable			
Regular			
Intercompany			
Inventories			
Prepaid Expenses			
Other			
<b>Total Current Assets</b>			
<b>Land, Building and Equipment</b>			
(less accumulated depreciation)			
Land			
Building			
Leasehold Improvements			
Equipment			
Motor Vehicles			
<b>Total Land, Building and Equipment</b>			

**SCHEDULE 'E'**

Operating Company: \_\_\_\_\_

**BALANCE SHEET**

<b>ASSETS</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Other Assets</b>			
Investments			
Deposits (Specify)			
Due from Officers/Owners			
Special Funds			
Start- up Costs			
Organization Costs			
<b>Total Other Assets</b>			
<b>TOTAL ASSETS</b>			

Operating Company: \_\_\_\_\_

**SCHEDULE 'E'**

**BALANCE SHEET**

<b>LIABILITIES AND CAPITAL</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Current Liabilities</b>			
Accounts Payable			
Regular			
Intercompany			
Notes Payable			
Current Financing			
Salaries Payable			
Payroll Taxes Payable			
Deferred Income			
Loan from Owners/Officers			
Other (Specify)			
<b>Total Current Liabilities</b>			
<b>Long Term Liabilities</b>			
Mortgage Payable			
Notes Payable			
Unsecured Loans			
Loans from Owners/Officers			
<b>Total Long Term Liabilities</b>			
<b>TOTAL LIABILITIES</b>			
<b>CAPITAL</b>			
Capital			
Retained Earnings			
Current Income			
<b>Total Capital</b>			
<b>TOTAL LIABILITIES &amp; CAPITAL</b>			

Realty Company (if applicable): \_\_\_\_\_

**SCHEDULE 'E'**

**BALANCE SHEET**

<b>ASSETS</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Current Assets</b>			
Cash in bank and on hand			
Investments			
Notes Receivable			
Other Receivable			
Accounts Receivable			
Regular			
Intercompany			
Inventories			
Prepaid Expenses			
Other			
<b>Total Current Assets</b>			
<b>Land, Building and Equipment</b>			
(less accumulated depreciation)			
Land			
Building			
Leasehold Improvements			
Equipment			
Motor Vehicles			
<b>Total Land, Building and Equipment</b>			

Realty Company (if applicable): \_\_\_\_\_

**SCHEDULE 'E'**

**BALANCE SHEET**

<b>ASSETS</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Other Assets</b>			
Investments			
Deposits (Specify)			
Due from Officers/Owners			
Special Funds			
Start- up Costs			
Organization Costs			
<b>Total Other Assets</b>			
<b>TOTAL ASSETS</b>			



Realty Company: (if applicable): \_\_\_\_\_

**SCHEDULE 'E'**

**BALANCE SHEET**

<b>LIABILITIES AND CAPITAL</b>		<b><u>DECEMBER 31, 2013</u></b>	<b><u>DECEMBER 31, 2012</u></b>
<b>Current Liabilities</b>			
Accounts Payable			
Regular			
Intercompany			
Notes Payable			
Current Financing			
Salaries Payable			
Payroll Taxes Payable			
Deferred Income			
Loan from Owners/Officers			
Other (Specify)			
<b>Total Current Liabilities</b>			
<b>Long Term Liabilities</b>			
Mortgage Payable			
Notes Payable			
Unsecured Loans			
Loans from Owners/Officers			
<b>Total Long Term Liabilities</b>			
<b>TOTAL LIABILITIES</b>			
<b>CAPITAL</b>			
Capital			
Retained Earnings			
Current Income			
<b>Total Capital</b>			
<b>TOTAL LIABILITIES &amp; CAPITAL</b>			