STATE OF RHODE ISLAND
OFFICE OF HEALTH & HUMAN SERVICES / DEPARTMENT OF HUMAN SERVICES (OHHS/DHS)
RATE SETTING UNIT

BM 64 SUPPLEMENTAL WORKSHEET CALENDAR YEAR 2013
{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 DHS/OHHS 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.

_____
_____

(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.

_____
_____

(2)

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

2013	2012
$ _____	$ _____

(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, 2013 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).

_____

(4)

Please complete the following schedule on liquidity:

		12/31/2013	12/31/2012
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, 2012 and 2013.

		2013	2012
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 2013?
_____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.

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, whose BM 64 Supplemental 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.

Signature of Owner, Partner or Officer	Title	Date

Signature of Other Preparer	Title	Date

(Original Signatures are Required) (Do not use Stamp or Submit Copy of This Page)