STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES
RATE SETTING UNIT
VIRKS BUILDING, 3 WEST ROAD
CRANSTON, RHODE ISLAND 02920

BM-64 REPORT FOR CALENDAR YEAR 2020

INSTRUCTIONS FOR COMPLETION OF BM-64 REPORT

The BM-64 Cost Report Schedules must reflect activity for calendar year 2020. The 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. Incomplete reports 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 five 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 BM-64 COST REPORT SCHEDULES (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 agree with the facility's general ledger.

Expenses per the general ledger should be listed on the appropriate lines in columns 1 and 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

Use this schedule 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:
Total adjustments shown in Schedule 'A-1' must agree with the total adjustments to income and expenses as shown in column 4, Schedule 'A'.

Schedule 'B' – Statement of Operations

Use this schedule to compare operations as reported for the year ended December 31, 2019 and operations for the year ended December 31, 2020. Reported amounts 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

Use this schedule to detail certain line items as reported in 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 [If Applicable]]

Use this schedule to 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

This schedule is to be used as a supporting statement to the depreciation claimed on Schedule 'A', column 3 and must agree with that amount. Each provider must 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.

Show the value of land 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

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.

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.

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.

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BM-64 REPORT FOR CALENDAR YEAR 2020

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 Ending _____ 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 12/31/20.
   _____ Title XVIII Certified _____ Nursing Facility Beds
   _____ Residential/ Assisted Living Beds _____ Other Beds(Specify)

3. Census Information: Nursing Facility

a. Licensed bed complement of facility at 12/31/20 _____

b. (i) Number of Rhode Island State patient days (Title XIX): FFS _____

b. (ii) Number of Rhode Island State patient days (Title XIX): Managed Care _____

c. Number of Massachusetts 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 _____

(Title XIX days are to be reported on lines "b" & "c" only)

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 365)

l. Percentage of occupancy (Item 3j divided by 3k). _____
(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.

_____ _____

_____ _____

_____ _____

Census Activity:

a. Total number of patients in facility on January 1, 2020 (12:01 am) _____

b. Total number of admissions during calendar year 2020 _____

c. Total of 4(a) plus 4 (b) _____

d. Total number of patients in facility on December 31, 2020 (11:59 pm) _____

e. Total number of discharges during calendar year 2020 _____

f. Total number of deaths during calendar year 2020 _____

g. Total of 4 (d) plus 4 (e) plus 4 (f) _____

Note: Lines 4c and 4g must agree.

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:

Name of Affiliated Company/Individual	Percentage of Ownership
_____	_____
_____	_____
_____	_____
_____	_____

7. What was your average daily room and board charge for private-paying patients in semi-private rooms during calendar year 2020?

   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 2020 for this facility $ _____
   (Attach Schedule if necessary)

9. a. State Income Tax calendar or fiscal 2020 $ _____
   Federal Income Tax calendar or fiscal 2020 $ _____

   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.

Page Number	Account Number	Amount
_____	_____	_____
_____	_____	_____

BM-64 Cost Report CY 2020
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

_____ _____
Name of Facility Facility Lic. #

This is the Original Signature Page that pertains to the BM-64 Cost Report for Calendar Year 2020 that was submitted to the state by email, in electronic form, on _____
mm / dd / yyyy

Signature of Owner, Partner or Officer Title Date
See instructions.

_____
(Print name of signatory listed above)

Signature of Preparer Title Date

Do not use a signature stamp.
For CY2020 Only, due to the Public Health Emergency, this signed page is to be submitted Only Electronically, by email to arthur.abraham@ohhs.ri.gov

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
	PASS THROUGH ITEMS					
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				
	Total					
	HEALTH CARE PROVIDER ASSESSMENT					
8470	Provider Assessment	XXXXXX				XXXXXX
	Total					
	FAIR RENTAL VALUE SYSTEM					
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
	Total					

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
	DIRECT LABOR					
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			
	Subtotal					

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
	DIRECT LABOR (Cont'd)					
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					
	Total					
	OTHER OPERATING EXPENSES					
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

Acct. No.	Name	Salaries Column 1	Other Column 2	Total Column 3	Adjustments Column 4	Adjusted Trial Balance Column 5
	Other Operating Expenses (Cont'd)					
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

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

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
	Nurse's Aide Training &					XXXXXXX
	Evaluation Program					XXXXXXX
	Salaries					XXXXXXX
	Supplies/Materials	XXXXXX				XXXXXXX
	Other					XXXXXXX
	Total					XXXXXXX
	TOTAL OPERATING EXPENSES					

SCHEDULE 'A'

ADJUSTMENT OF TRIAL BALANCE

Acct. No.	Name			Total Column 3	Adjustments Column 4	Adjusted Trial Balance Column 5
0300	**GROSS INCOME**					
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

Acct. No.	Name			Total Column 3	Adjustments Column 4	Adjusted Trial Balance Column 5
	GROSS INCOME (Continued)					
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			
	TOTAL GROSS INCOME					

SCHEDULE 'A-1'

ADJUSTMENTS
EXPENSES

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

SCHEDULE 'A-1'

ADJUSTMENTS
INCOME

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

SCHEDULE 'B'

STATEMENT OF OPERATIONS-CALENDAR YEARS		**Dec.31, 2020**	**Dec.31, 2019**
PASS THROUGH ITEMS COST CENTER		**$**	**$**
1451	Real Estate Taxes		
1451A	Personal Property Taxes		
1451B	Fire Tax		
2512	Fuel		
2513	Gas		
2514	Electricity		
5442	Insurance (Complete Schedule 'B-1')		
	TOTAL		
DIRECT LABOR COST CENTER			
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-l')		
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		
	TOTAL		

SCHEDULE 'B'

STATEMENT OF OPERATIONS-CALENDAR YEARS **Dec.31, 2020** **Dec.31, 2019**

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	_____	_____

OTHER OPERATING COST CENTER (continued)			**Dec. 31, 2020**	**Dec. 31, 2019**
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			
	TOTAL	**$**		
	TOTAL EXPENSES	**$**		

SCHEDULE 'B'

STATEMENT OF OPERATIONS-CALENDAR YEARS		**Dec.31, 2020**	**Dec.31, 2019**
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)		
	_____		
	TOTAL GROSS INCOME **$**		

SCHEDULE 'B-1'

ANALYSIS OF CERTAIN LINE ITEMS

Page	Account No.	Name	Explanation	Amount $
16	5442	Insurance:		
		TYPE		
		Liability Insurance _____		_____
		Malpractice Insurance (Audited Premium)		_____
		Property Insurance _____		_____
		Personal Needs Surety Bond		_____
		Other Bond/s		_____
		Motor Vehicle Insurance :		
		1st Auto _____ Adjust to allowable (_____)		_____
		2nd Auto _____ Adjust to allowable (_____)		_____
		3rd Auto _____ Adjust to allowable (_____)		_____
		Mortgage Insurance Premium (MIP)	$_____	
		Adjustment to Medicaid allowable principal	(_____)	
		Allowable Mortgage Insurance Premium	_____	_____
		Medicaid Allowable Principal	_____	
		Medicaid Allowable Percentage	_____	_____
		TOTAL	**$**	_____
16, 17	4432 & 7432	Other Employee Fringe (Include the total reported in the two accounts:)		
		Pension_____		_____
		Employee Physicals__		_____
		Employee Parties____		_____
		Life Insurance_____		_____
		Other_____		_____
		_____		_____
		TOTAL	**$**	_____
16	4715B	Other Therapeutic Services – Title XIX – Medicaid:		
		_____		_____
		_____		_____
		_____		_____
		TOTAL $		_____

SCHEDULE 'B-1'

ANALYSIS OF CERTAIN LINE ITEMS (CONT'D)

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

SCHEDULE 'B-2'

INTEREST AND INDEBTEDNESS SCHEDULE (TO BE COMPLETED IN DETAIL)

Date of Loan	Creditor	Original Principal	Principal Jan. 1, 2020	Balance Dec. 31, 2020	Term	Interest Rate	Purpose Of Borrowing	Interest Amount

SCHEDULE 'B-3'

DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL)

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/20	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	

SCHEDULE 'B-3'

DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL) CONTINUED

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/20	REMAINING BASE	RATE	METHOD	DEPR. CLAIMED
LEASEHOLD IMPROV.									
TOTAL LEASEHOLD IMPROVEMENTS				XXX			XXX	XXX	
EQUIPMENT									
TOTAL EQUIPMENT				XXXXXX			XXXX	XXXXXX	

SCHEDULE 'B-3'

DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL) CONTINUED

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/20	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**

SCHEDULE 'B-3'

DEPRECIATION SCHEDULE (TO BE COMPLETED IN DETAIL)

DESCRIPTION	COST	SALVAGE VALUE	DEPR. BASE	MONTH & YEAR ACQUIRED	ACCUM. DEPR. AT 1/1/20	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 2020.

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 2020 Employer's Quarterly Federal Tax Return (Form 941). **[Not Required for CY2020]** 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.

PAYROLL AND PAYROLL TAX INFORMATION **SCHEDULE 'D'**

Please complete the following information from your employer's Federal and State Payroll Tax Returns for the four quarters in 2020.

Quarter Ending Date	-1- Total Gross Wages Per Quarter	-2- F.I.C.A. Employer's Share Per Quarter	-3- Federal Unemployment Tax Per Quarter	-4- State Unemployment Tax Per Quarter
1.				
2.				
3.				
4.				
SUB-TOTAL				
P/R REVERSAL	( )	( )	( )	( )
P/R ACCRUAL				
VAC. REVERSAL	( )	( )	( )	( )
VAC. ACCRUAL				
SEC. 125				
AUTO	( )	( )	( )	( )
HEALTH INSURANCE	( )	( )	( )	( )
BONUS REVERSAL	( )	( )	( )	( )
BONUS ACCRUAL				
TOTAL				

Column 1 to agree with reported salaries on schedule 'A'.
Total of Columns 2, 3 and 4 to agree with amount reported in Account Nos.4440 & 7440 on Schedule 'A'.

STATEMENT OF COMPENSATION 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	Number of Hours Devoted Weekly	Salary Included In Schedule 'A'

STATEMENT OF COMPENSATION PAID TO ADMINISTRATORS/AND OR ASSISTANT ADMINISTRATORS (OTHER THAN OWNERS)

Name	Title or Job Function	Number of Hours Devoted Weekly	Salary Included In Schedule 'A'

SCHEDULE 'D'

STATEMENT OF TOTAL HOURS WORKED

Hours compensated but not worked, such as vacation, sick, holiday, should NOT be included in this schedule**.**

DEPARTMENT	Hours: 1/1/20 – 12/31/20	Hours: 1/1/19 – 12/31/19
Payroll Hours:		
Administrative & General		
Nursing:		
D.N.S.		
R.N.'s (exclusive of D.N.S.)		
L.P.N.'s		
Med. Tech.		
Aides & Others		
Total-Nursing		
Dietary		
Housekeeping		
Maintenance		
Laundry		
Recreational		
All other (itemize)		
…		
Total Payroll		
Purchased Service Hours:		
R.N.'s		
L.P.N.'s		
Aides & Others		
….All other (itemize		
…		
Total Purchased Services		
Consultant Hours:		
… Nursing		
Medical Director		
Pharmacist		
Dietician		
Social Worker		
All other (itemize)		
…		
Total Consultant		
TOTAL ALL HOURS		

Operating Company:_____

SCHEDULE 'E'

BALANCE SHEET

ASSETS		**DECEMBER 31, 2020**	**DECEMBER 31, 2019**
Current Assets			
Cash in bank and on hand			
Investments			
Notes Receivable			
Other Receivable			
Accounts Receivable			
Regular			
Intercompany			
Inventories			
Prepaid Expenses			
Other			
Total Current Assets			
Land, Building and Equipment			
(less accumulated depreciation)			
Land			
Building			
Leasehold Improvements			
Equipment			
Motor Vehicles			
Total Land, Building and Equipment			

SCHEDULE 'E'

Operating Company:_____

BALANCE SHEET

ASSETS		DECEMBER 31, 2020	DECEMBER 31, 2019
Other Assets			
Investments			
Deposits (Specify)			
Due from Officers/Owners			
Special Funds			
Start- up Costs			
Organization Costs			
Total Other Assets			
TOTAL ASSETS			

Operating Company:_____

SCHEDULE 'E'

BALANCE SHEET

LIABILITIES AND CAPITAL		DECEMBER 31, 2020	DECEMBER 31, 2019
Current Liabilities			
Accounts Payable			
Regular			
Intercompany			
Notes Payable			
Current Financing			
Salaries Payable			
Payroll Taxes Payable			
Deferred Income			
Loan from Owners/Officers			
Other (Specify)			
Total Current Liabilities			
Long Term Liabilities			
Mortgage Payable			
Notes Payable			
Unsecured Loans			
Loans from Owners/Officers			
Total Long Term Liabilities			
TOTAL LIABILITIES			
CAPITAL			
Capital			
Retained Earnings			
Current Income			
Total Capital			
TOTAL LIABILITIES & CAPITAL			

Realty Company (if applicable):_____

SCHEDULE 'E'

BALANCE SHEET

ASSETS		DECEMBER 31, 2020	DECEMBER 31, 2019
Current Assets			
Cash in bank and on hand			
Investments			
Notes Receivable			
Other Receivable			
Accounts Receivable			
Regular			
Intercompany			
Inventories			
Prepaid Expenses			
Other			
Total Current Assets			
Land, Building and Equipment			
(less accumulated depreciation)			
Land			
Building			
Leasehold Improvements			
Equipment			
Motor Vehicles			
Total Land, Building and Equipment			

Realty Company (if applicable):_____ **SCHEDULE 'E'**

BALANCE SHEET

ASSETS		DECEMBER 31, 2020	DECEMBER 31, 2019
Other Assets			
Investments			
Deposits (Specify)			
Due from Officers/Owners			
Special Funds			
Start- up Costs			
Organization Costs			
Total Other Assets			
TOTAL ASSETS			

Realty Company: (if applicable):_____

SCHEDULE 'E'

BALANCE SHEET

LIABILITIES AND CAPITAL		DECEMBER 31, 2020	DECEMBER 31, 2019
Current Liabilities			
Accounts Payable			
Regular			
Intercompany			
Notes Payable			
Current Financing			
Salaries Payable			
Payroll Taxes Payable			
Deferred Income			
Loan from Owners/Officers			
Other (Specify)			
Total Current Liabilities			
Long Term Liabilities			
Mortgage Payable			
Notes Payable			
Unsecured Loans			
Loans from Owners/Officers			
Total Long Term Liabilities			
TOTAL LIABILITIES			
CAPITAL			
Capital			
Retained Earnings			
Current Income			
Total Capital			
TOTAL LIABILITIES & CAPITAL			