Reset Form

INDEPENDENT VERIFICATION OF ASSETS AND LIABILITIES

State Form 51996 (R2 / 5-13)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, 410 IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

Please Type or Print Legibly.

SECTION I – INSTRUCTIONS

Licensee:

1. Complete sections II, III, and F & G in section IV.
2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process.
3. All financial information listed on this form should be for the applicant entity listed on SF 8200 Application for Licensure to Operate a Health Care Facility and Section III of this form, it should not be the parent company's financial information.
4. Forward the completed materials to an Independent Certified Public Accountant.
5. Upon receipt from the CPA, sign and date the certification statement in section V (Name of Authorized Person).

CPA:

1. Complete Section IV on the reverse side of this form using the applicant entity's current balance sheet and a projection of revenue and operating expenses. Attach additional schedules or information as necessary for the documentation requested.
2. Sign and date the certification statement in Section V.
3. This form must be returned with the application materials, including the balance sheet and projection of revenue and operating expenses for the applicant entity, in order to complete the application process.
4. All financial information listed on this form should be for the applicant entity listed on State Form 8200, Application for Licensure to Operate a Health Care Facility, and Section III of this form, it should not be the parent company's financial information.

SECTION II - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease (mm/dd/yy)*):**_____ ☐ **New Facility** ☐ **Other:**_____

SECTION III - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility			
Street Address *(number and street)*			
City		County	ZIP Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd)*:	To *(mm/dd)*:

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) *Same as Licensee on State Form 8200, Application for License to Operate a Health Facility, Section B.*		
Street Address *(number and street)*		P.O. Box
City	State	ZIP Code + 4

SECTION IV – SELECTED BALANCE SHEET ITEMS AS OF_____

(mm/dd/yy)

A. Current Assets:		**B. Current Liabilities:**	
Asset	**Amount** ***(rounded to nearest dollar)***	**Liability**	**Amount** ***(rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: ***(Total Current Assets minus Total Current Liabilities)*** **$_____**

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $ _____**

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary.)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: $_____

Projected Monthly Operating Expenses: $_____

SECTION V – CERTIFICATION STATEMENTS

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations, is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date** ***(mm/dd/yy)***

In my opinion, the information reported above presents fairly, in all material respects, the current assets, current liabilities, working capital, the total liabilities and total owner's equity or fund balance as well as lines of credit available as of the date identified above. Additionally, we have reviewed management's underlying assumptions and believe that they provide a reasonable basis for the projected monthly revenue and operating expense.

Name of Independent Certified Public Accountant (*Typed*)	**Title/Position**	
Signature of Independent Certified Public Accountant	**License/Certification Number**	**Date** ***(mm/dd/yy)***