SCHEDULE 7 **Nursing Homes** **PROJECTED REVENUES**

PROJECTED OPERATING YEAR 1 (ENDING _____):

		SELF PAY Col. 1	MEDICAID Col. 2	MEDICAID HMO Col. 3	MEDICARE Col. 4	MEDICARE HMO Col. 5	COMMERCIAL INSURANCE Col. 6	OTHER MANAGED CARE Col. 7	OTHER PAYERS Col. 8	OTHER REVENUE Col. 9	TOTAL Col. 10
1	Routine Services										
2	Physical Therapy										
3	Speech Therapy										
4	Occupational Therapy										
5	Audiological Therapy										
6	Medical Supplies										
7	Pharmacy										
8	Laboratory										
9	Radiology										
10	Other Ancillary										
11	Unrestricted Grants/Donations										
12	Outpatient Clinic										
13	Other Nursing Home Revenue										
14	Charity Allowance										
15	Contractual Adjustments										
16	Prior Year Cost Settlements										
17	**TOTAL NURSING HOME REVENUE**										
18	Restricted Grants/Donations										
19	**NON NURSING HOME REVENUES**										
20	**TOTAL REVENUE**										
21	% of Nursing Home Revenue										100%
22	**TOTAL ADMISSIONS**										
23	**TOTAL PATIENT DAYS**										
24	% of Total Patient Days										100%
25	**REVENUE PER PATIENT DAY**	$	$	$	$	$	$	$	$	$	$

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of Nursing Home Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for Nursing Home Bed _____%

29 Average Occupancy for Other Beds _____%

SCHEDULE 7 **Nursing Homes**

PROJECTED REVENUES

PROJECTED OPERATING YEAR 2 (ENDING _____):

		SELF PAY Col. 1	MEDICAID Col. 2	MEDICAID HMO Col. 3	MEDICARE Col. 4	MEDICARE HMO Col. 5	COMMERCIAL INSURANCE Col. 6	OTHER MANAGED CARE Col. 7	OTHER PAYERS Col. 8	OTHER REVENUE Col. 9	TOTAL Col. 10
1	Routine Services									\\\\\\\\\\\\\\\\	
2	Physical Therapy									\\\\\\\\\\\\\\\\	
3	Speech Therapy									\\\\\\\\\\\\\\\\	
4	Occupational Therapy									\\\\\\\\\\\\\\\\	
5	Audiological Therapy									\\\\\\\\\\\\\\\\	
6	Medical Supplies									\\\\\\\\\\\\\\\\	
7	Pharmacy									\\\\\\\\\\\\\\\\	
8	Laboratory									\\\\\\\\\\\\\\\\	
9	Radiology									\\\\\\\\\\\\\\\\	
10	Other Ancillary									\\\\\\\\\\\\\\\\	
11	Unrestricted Grants/Donations	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\		
12	Outpatient Clinic	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\		
13	Other Nursing Home Revenue	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\		
14	Charity Allowance		\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	
15	Contractual Adjustments	\\\\\\\\\\\\\\\\								\\\\\\\\\\\\\\\\	
16	Prior Year Cost Settlements	\\\\\\\\\\\\\\\\					\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	
17	**TOTAL NURSING HOME REVENUE**										
18	Restricted Grants/Donations	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\		
19	**NON NURSING HOME REVENUES**	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\		
20	**TOTAL REVENUE**										
21	% of Nursing Home Revenue										100%
22	**TOTAL ADMISSIONS**										
23	**TOTAL PATIENT DAYS**										
24	% of Total Patient Days										100%
25	**REVENUE PER PATIENT DAY**	$	$	$	$	$	$	$	$	$	$

Attach notes describing assumptions used in projecting revenues.

PLEASE SHOW PROJECTED REVENUES FOR THE TOTAL OF LICENSED BEDS AT YOUR FACILITY. IF YOUR PROJECT EXPANDS EXISTING CAPACITY, INCLUDE A DUPLICATE OF THIS FORM THAT SHOWS PROJECTED REVENUES **ONLY** FOR THE ADDED BEDS.

26 Total Number of Nursing Home Beds _____

27 Total Number of Other Beds _____

28 Average Occupancy for Nursing Home Bed _____%

29 Average Occupancy for Other Beds _____%

Rule 59C-1.008(1)(f), Florida Administrative Code

Form available at: http://ahca.myflorida.com/MCHQ/CON_FA/Application/index.shtml