SCHEDULE 7B

ICF/DDs

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 Revenue	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	_________	_________
14	Charity Allowance	_________	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	_________
15	Contractual Adjustments	\\\\\\\\\\\\\\\\	_________	_________	_________	_________	_________	_________	_________	\\\\\\\\\\\\\\\\	_________
16	Prior Year Cost Settlements	\\\\\\\\\\\\\\\\	_________	_________	_________	_________	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	_________
17	**TOTAL ICF/DD REVENUE**	_________	_________	_________	_________	_________	_________	_________	_________	_________	_________
18	Restricted Grants/Donations	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	_________	_________
19	**NON ICF/DD REVENUES**	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	\\\\\\\\\\\\\\\\	_________	_________
20	**TOTAL REVENUE**	_________	_________	_________	_________	_________	_________	_________	_________	_________	_________
21	% of ICF/DD 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 ICF/DD Beds	________
27	Total Number of Other Beds	________
28	Average Occupancy for ICF/DD Beds	________%
29	Average Occupancy for Other Beds	________%

SCHEDULE 7B	**ICF/DDs**	**PROJECTED REVENUES**

PROJECTED OPERATING YEAR 2 (ENDING __________):

	SELF PAY Col. 11	MEDICAID Col. 12	MEDICAID HMO Col. 13	MEDICARE Col. 14	MEDICARE HMO Col. 15	COMMERCIAL INSURANCE Col. 16	OTHER MANAGED CARE Col. 17	OTHER PAYERS Col. 18	OTHER REVENUE Col. 19	TOTAL Col. 20
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 ICF/DD REVENUE**	________	________	________	________	________	________	________	________	________	________
18 Restricted Grants/Donations	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	________	________
19 **NON ICF/DD REVENUES**	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	\\\\\\\\\\\\	________	________
20 **TOTAL REVENUE**	________	________	________	________	________	________	________	________	________	________
21 % of ICF/DD 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 ICF/DD Beds	________
27	Total Number of Other Beds	________
28	Average Occupancy for ICF/DD Beds	________%
29	Average Occupancy for Other Beds	________%

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