SCHEDULE 8A **Hospice and ICF/DDs**

PROJECTED INCOME AND EXPENSES

PROJECTED YEAR 1 (ENDING _____)

		INCLUDING THIS PROJECT		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE	
		Amount	Per Patient Day(1)	Amount	Per Patient Day(1)	Amount	Per Patient Day(1)
		Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
NET OPERATING REVENUE							
1	SCHEDULE 7A , LINE 14, COLUMN 10 OR SCHEDULE 7B, LINE 17, COLUMN 10	$_____	$_____	$_____	$_____	$_____	$_____
EXPENSES							
	PATIENT SERVICE						
2	Nursing	_____	_____	_____	_____	_____	_____
3	Other	_____	_____	_____	_____	_____	_____
	ANCILLARY						
4	Physical Therapy	_____	_____	_____	_____	_____	_____
5	Speech Therapy	_____	_____	_____	_____	_____	_____
6	Occupational Therapy	_____	_____	_____	_____	_____	_____
7	Medical Supplies	_____	_____	_____	_____	_____	_____
8	Radiology	_____	_____	_____	_____	_____	_____
9	Laboratory	_____	_____	_____	_____	_____	_____
10	Pharmacy	_____	_____	_____	_____	_____	_____
11	Other	_____	_____	_____	_____	_____	_____
12	**TOTAL ANCILLARY**	$_____	$_____	$_____	$_____	$_____	$_____
13	Ambulatory	_____	_____	_____	_____	_____	_____
	ADMINISTRATION AND OVERHEAD						
14	Plant Operations	_____	_____	_____	_____	_____	_____
15	Housekeeping	_____	_____	_____	_____	_____	_____
16	Administration	_____	_____	_____	_____	_____	_____
17	Other	_____	_____	_____	_____	_____	_____
18	**TOTAL ADMINISTRATION AND OVERHEAD**	$_____	$_____	$_____	$_____	$_____	$_____

(1) For utilization other than "patient day," use the applicable measure consistent with Schedules 5 and 7A.

PROJECTED INCOME AND EXPENSES

PROJECTED YEAR 1 (ENDING _____)

		INCLUDING THIS PROJECT		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE	
		Amount	Per Patient Day(1)	Amount	Per Patient Day(1)	Amount	Per Patient Day(1)
		Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	PROPERTY COSTS						
19	Depreciation and Amortization	_____	_____	_____	_____	_____	_____
20	Interest	_____	_____	_____	_____	_____	_____
21	Rent	_____	_____	_____	_____	_____	_____
22	Insurance	_____	_____	_____	_____	_____	_____
23	Taxes	_____	_____	_____	_____	_____	_____
24	**TOTAL PROPERTY COSTS**	$_____	$_____	$_____	$_____	$_____	$_____
25	**OTHER OPERATING COSTS**	$_____	$_____	$_____	$_____	$_____	$_____
26	**TOTAL OPERATING EXPENSES**	$_____	$_____	$_____	$_____	$_____	$_____
27	**NET PROFIT FROM OPERATIONS**	$_____	$_____	$_____	$_____	$_____	$_____
28	**NON-OPERATING REVENUES**	$_____	$_____	$_____	$_____	$_____	$_____
	NON-OPERATING EXPENSES						
29	Income Taxes	_____	_____	_____	_____	_____	_____
30	Other	_____	_____	_____	_____	_____	_____
31	**TOTAL NON-OPERATING EXPENSES**	$_____	_____	_____	_____	_____	_____
32	**NET PROFIT (OR LOSS)**	$_____	$_____	$_____	$_____	$_____	$_____

SCHEDULE 8A **Hospice and ICF/DDs**

PROJECTED INCOME AND EXPENSES

PROJECTED YEAR 2 (ENDING _____)

		INCLUDING THIS PROJECT		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE	
		Amount	Per Patient Day(1)	Amount	Per Patient Day(1)	Amount	Per Patient Day(1)
		Col. 7	Col. 8	Col. 9	Col. 10	Col. 11	Col. 12
NET OPERATING REVENUE							
1	SCHEDULE 7A, LINE 14, COLUMN 10 OR SCHEDULE 7B, LINE 17, COLUMN 20	$_____	$_____	$_____	$_____	$_____	$_____
EXPENSES							
	PATIENT SERVICE						
2	Nursing	_____	_____	_____	_____	_____	_____
3	Other	_____	_____	_____	_____	_____	_____
	ANCILLARY						
4	Physical Therapy	_____	_____	_____	_____	_____	_____
5	Speech Therapy	_____	_____	_____	_____	_____	_____
6	Occupational Therapy	_____	_____	_____	_____	_____	_____
7	Medical Supplies	_____	_____	_____	_____	_____	_____
8	Radiology	_____	_____	_____	_____	_____	_____
9	Laboratory	_____	_____	_____	_____	_____	_____
10	Pharmacy	_____	_____	_____	_____	_____	_____
11	Other	_____	_____	_____	_____	_____	_____
12	**TOTAL ANCILLARY**	$_____	$_____	$_____	$_____	$_____	$_____
13	Ambulatory	_____	_____	_____	_____	_____	_____
	ADMINISTRATION AND OVERHEAD						
14	Plant Operations	_____	_____	_____	_____	_____	_____
15	Housekeeping	_____	_____	_____	_____	_____	_____
16	Administration	_____	_____	_____	_____	_____	_____
17	Other	_____	_____	_____	_____	_____	_____
18	**TOTAL ADMINISTRATION AND OVERHEAD**	$_____	$_____	$_____	$_____	$_____	$_____

(1) For utilization other than "patient day," use the applicable measure consistent with Schedules 5 and 7A.

PROJECTED INCOME AND EXPENSES

PROJECTED YEAR 2 (ENDING _____)

		INCLUDING THIS PROJECT		WITHOUT THIS PROJECT		INCREMENTAL DIFFERENCE	
		Amount	Per Patient Day(1)	Amount	Per Patient Day(1)	Amount	Per Patient Day(1)
		Col. 7	Col. 8	Col. 9	Col. 10	Col. 11	Col. 12
	PROPERTY COSTS						
19	Depreciation and Amortization	_____	_____	_____	_____	_____	_____
20	Interest	_____	_____	_____	_____	_____	_____
21	Rent	_____	_____	_____	_____	_____	_____
22	Insurance	_____	_____	_____	_____	_____	_____
23	Taxes	_____	_____	_____	_____	_____	_____
24	**TOTAL PROPERTY COSTS**	$_____	$_____	$_____	$_____	$_____	$_____
25	**OTHER OPERATING COSTS**	$_____	$_____	$_____	$_____	$_____	$_____
26	**TOTAL OPERATING EXPENSES**	$_____	$_____	$_____	$_____	$_____	$_____
27	**NET PROFIT FROM OPERATIONS**	$_____	$_____	$_____	$_____	$_____	$_____
28	**NON-OPERATING REVENUES**	$_____	$_____	$_____	$_____	$_____	$_____
	NON-OPERATING EXPENSES						
29	Income Taxes	_____	_____	_____	_____	_____	_____
30	Other	_____	_____	_____	_____	_____	_____
31	**TOTAL NON-OPERATING EXPENSES**	$_____	$_____	$_____	$_____	$_____	$_____
32	**NET PROFIT (OR LOSS)**	$_____	$_____	$_____	$_____	$_____	$_____