**Limited Review Application**

# Schedule LRA 7

**State of New York Department of Health**

**Office of Primary Care and Health Systems Management**

**Proposed Operating Budget**

|  |  |  |  |
| --- | --- | --- | --- |
| **Budget** | **Current Year** | **First Year**  **(Projected)** | **Third Year**  **(Projected)** |
| **Revenues** | | | |
| Service Revenue |  |  |  |
| Grants Funds |  |  |  |
| Foundation |  |  |  |
| Other |  |  |  |
| Fees |  |  |  |
| Other Income |  |  |  |
| **(1)** Total Revenues | $ | $ | $ |
| **Expenses** | | | |
| Salaries and Wage Expense |  |  |  |
| Employee Benefits |  |  |  |
| Professional Fees |  |  |  |
| Medical & Surgical Supplies |  |  |  |
| Non-Medical Equipment |  |  |  |
| Purchased Services |  |  |  |
| Other Direct Expense |  |  |  |
| Utilities Expense |  |  |  |
| Interest Expense |  |  |  |
| Rent Expense |  |  |  |
| Depreciation Expense |  |  |  |
| Other Expenses |  |  |  |
| **(2)** Total Expense | $ | $ | $ |
| ***Net Total - (1-2)*** | ***$*** | ***$*** | ***$*** |

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**Limited Review Application**

# Schedule LRA 7A

**State of New York Department of Health**

**Office of Primary Care and Health Systems Management**

Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days  Patient discharges

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Inpatient Services  Source of Revenue | | Total Current Year | | | First Year Incremental | | | Third Year Incremental | | |
| Patient  Days or dis-charges | Net Revenue\* | | Patient  Days or dis-charges | Net Revenue\* | | Patient  Days or dis-charges | Net Revenue\* | |
| % | Dollars ($) | % based on days or discharges | Dollars-$ | % based on days or discharges | Dollars-$ |
| Commercial | Fee for Service |  |  |  |  |  |  |  |  |  |
| Managed Care |  |  |  |  |  |  |  |  |  |
| Medicare | Fee for Service |  |  |  |  |  |  |  |  |  |
| Managed Care |  |  |  |  |  |  |  |  |  |
| Medicaid | Fee for Service |  |  |  |  |  |  |  |  |  |
| Managed Care |  |  |  |  |  |  |  |  |  |
| Private Pay | |  |  |  |  |  |  |  |  |  |
| OASAS | |  |  |  |  |  |  |  |  |  |
| OMH | |  |  |  |  |  |  |  |  |  |
| Charity Care | |  |  |  |  |  |  |  |  |  |
| Bad Debt | |  |  |  |  |  |  |  |  |  |
| All Other | |  |  |  |  |  |  |  |  |  |
| Total | |  | 100% |  |  | 100% |  |  | 100% |  |

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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Outpatient Services  Source of Revenue | | | Total Current Year | | | First Year Incremental | | | Third Year Incremental | | |
| Visits | Net Revenue\* | | Visits | Net Revenue\* | | Visits | Net Revenue\* | |
| % | Dollars ($) | % | Dollars ($) | % | Dollars ($) |
| Commercial | Fee for Service | |  |  |  |  |  |  |  |  |  |
| Managed Care | |  |  |  |  |  |  |  |  |  |
| Medicare | Fee for Service | |  |  |  |  |  |  |  |  |  |
| Managed Care | |  |  |  |  |  |  |  |  |  |
| Medicaid | Fee for Service | |  |  |  |  |  |  |  |  |  |
| Managed Care | |  |  |  |  |  |  |  |  |  |
| Private Pay | | |  |  |  |  |  |  |  |  |  |
| OASAS | | |  |  |  |  |  |  |  |  |  |
| OMH | | |  |  |  |  |  |  |  |  |  |
| Charity Care | | |  |  |  |  |  |  |  |  |  |
| Bad Debt | | |  |  |  |  |  |  |  |  |  |
| All Other | | |  |  |  |  |  |  |  |  |  |
| Total | | |  | 100% |  |  | 100% |  |  | 100% |  |
|  | |  |  |  |  |  |  |  |  |  |  |
| Total of Inpatient and Outpatient Services | | |  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Title of Attachment** | **Filename of attachment** |
| 1. In an attachment, provide the basis and supporting calculations for all revenues by payor. |  |  |
| 2. In an attachment, provide the basis for charity care. |  |  |

\*Net of Deductions from Revenue

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