					OM	B No.: 0915-0285.	. Expiration Dat	te: 10/31/2013			
DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3: INCOME ANALYSIS YEAR 1 I YEAR 2 II				3	FOR HRSA USE ONLY						
					Applicant Name						
					Grant Number			Application Tracking Number			
Note: The valu	ue in the Projected	Income (d) co	lumn should	l equal the valu	al the value in the Billable Visits (b) column multiplied by the value in the						
Income per Vi	sit (c) column. If no	ot, explain in th	le Comment	ts/Explanatory N	Notes box. Re	efer to the Fis					
Form 1A of the application to provide the information in the Prior FY Income (e) column.											
PART 1: NON FEDERAL SHAREPatient Service Revenue –, Program Income											
Payor	Category	Insurance	<del>Charge</del> <del>Per<u>Billable</u> Visit<u>s</u></del>	<del>(a*b)=(Income</del> per Visit <del>c)</del>	Adjustment Rate (%)	Billed) [c*(100-d)]-	Collection Rate (%)	Income <del>(e*f)</del>	Actual AccruedPrior FY Income Past 12 Months**		
		(a)	(b)	(C)	<del>(d)</del>	<del>(e)</del>	<del>(f)</del>	( <u>d</u> <del>g</del> )	( <u>e</u> h)		
1 N 4 1		, Carlo and Carl	PROJECTE	<del>D FEE FOR SE</del>	RVICE INCO	OME					
	caid: Medical	ļ	<sup> </sup>	l	ļ	l		<u> </u>	'		
1b. Medicaid: different from				1		1					
1c. Medicaid:	/	ļļ	<sup> </sup>	t	ļ,	ł			<u> </u>		
1d. Medicaid:		ļļ	<sup> </sup>	<u> </u>	ļļ	<u> </u>	'				
	Other Fee for	·		<u> </u>	++		'				
Service	Other Foc let			1	!						
2	ubtotal:	,	1		ļ,						
	ledicaid										
2a. Medicare:	All Inclusive										
FQHC Rate	Other Fee for	ļļ	<sup> </sup>	t	ļļ	l	<sup>1</sup>				
Service	Other r centre			1							
Su	ı <del>btotal:</del>	ļ ,			++		+				
	edicare	,		1							
<del>3a. Private In</del>	surance: Medical	· · · · · · · · · · · · · · · · · · ·		[	·!			<u> </u>			
3b. Private Ins	surance: Dental										
	<del>surance: BH/SA</del>	ļ!			ļ!						
	surance: Other	,		1		1					
Fee for Servic		ļļ	<sup> </sup>	<u> </u>	ļ!	<u> </u>		<u> </u>			
	ubtotal: Private	ļ!	<sup> </sup>	<del> </del>	ļ!	<b> </b>	'	<u> </u>			
4a. <del>Self-Pay: Discount (Mec</del>	100% Charge, No			1	!						
54b. Self -Pay		ļļ	<sup> </sup>	<u> </u>	ļļ	<u> </u>	'				
Charge, Slidin				1	!						
Including Full				1	!						
(Medical)		!		L							
	100% Charge, No	· · · · ·									
Discount (Den		ļ!	<sup> </sup>	<u> </u>	ļ!	l	'				
	0-99% of Charge, Ints Including Full			1	!						
Discount (Der	•	,		1							
	100% Charge, No	, <del> </del>		[	++		+		<u> </u>		
Discount (BH/	<del>SA)</del>	ļ!		<b> </b>	ļ!	ļ					
4t. Selt-Pay: 0	<del>)-99% of Charge,</del>	<u> </u>	<u>ا</u> ــــــــــــــــــــــــــــــــــــ	<u>I</u>	<u>ل</u> ــــــــــــــــــــــــــــــــــــ	<u> </u>					

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					Applicant Name						
					Grant Number				Applicatior Tracking Number		
Discount (BH/ 4g. Self-Pay: Discount (Oth 4h. Self-Pay: Sliding Discou Discount (Oth	100% Charge, No e <del>r)</del> 0-99% of Charge, Int Including Full er)										
4	Subtotal: Self Pay										
<del>5.</del> Publi 6. Total (Lines	<u>1-5)</u> OTAL FEE FOR										
	SERVICE ne period used for			act 12	Month	e by licting t	ho 12 month r	oriod and a	data (mont		
State the th	ne penoù useu ior	Actual Accrue	I Income Pa	<del>dSt 12</del>	monun	s by itsting ti	ne 12-monun p		uale (monti	<del>i anu year).</del>	
		PROJE(	CTED CAPI	TATE	D MAN/	AGED CARE					
	TYPE OF PAYOR		Mem Mont	Number of Member Months- ( <del>a)</del>		P <del>er Member</del> <del>Aonth-</del> ( <del>b)</del>	Risk Pool and Other Adjustments (c)		ent and ustments	<del>Projected</del> <del>Gross Income</del> <del>(e)</del>	
	7a. Medicaid										
7b. Medicare											
7c. Commerci	<del>al</del>										
7d. Other Pub	<del>lic</del>										
<del>7.</del>	TOTAL CAPIT/	ATED MANAGE CAR									
				<del>Visits</del> <del>(a)</del>		Average Charge Per Visit ( <del>b)</del>			F <del>otal Charges</del> <del>(c)</del>		
<del>8.</del>	Capitated Manage	ed Care									
	OGRAM INCOME ncome" of the SF		g + line 7,	<del>colun</del>	<del>nn e] m</del> a	atches line					
	I-FEDERAL SHAF		OME – Othe	er Fed	leral. St	ate Local	and Other Inc	ome			
Payor Catego						<u></u>			Projected Income (d)Total Other Income b Source	<u>Prior FY</u> Income (e)	
7. Other Fede	<u>ral</u> 10. Applicant Fu	unds (Retained E	<del>arnings)</del>								
	nds <u>Government</u>										
	nds <u>Government</u>										
	10. Private Grants										
	<u>utions</u> Other Federa										
1 <u>2</u> 3b. Contrib	utions and Fundrai	singOther									

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration	FOR HRSA USE ONLY						
Tealth Resources and Services Administration	Applicant Name						
FORM 3: INCOME ANALYSIS	Grant Number		Application Tracking Number				
13e <u>Applicant (Retained Earnings)</u> Foundation Grants							
<u>14</u> 13d. <u>Total Other(please listLines 7-13)</u>							
<del>13.</del>	- Support						
<del>14.</del>	TOTAL OTHER INCOME						
15. Total Non-Federal SHARE(Non-Health Center Program)							
[ <del>line 6, column g + line 7, column e + line 14] matches line 5</del> 424A							
<u> 15. Total Non-Federal (Lines 6 + 14)</u>							
Comments/Explanatory Notes (if applicable):							

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 2.51 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-3314N-39, Rockville, Maryland, 20857.