

Institutional Facility Per Diem Calculation Worksheet

County ID # :

County :

Certificate of Compliance # :

Facility Name:

Parent Organization:

Unit Identification # :

Facility Location:

Mailing Address:

Unit Name:

Type of Service:

				Delinquent/Dependent/Both:		
TOTAL AMOUNT CHARGED	Prior Year Actual FY_____	Title IV-E Allowable FY_____	Current Budget Year FY_____	Title IV-E Allowable FY_____	Projected Budget FY_____	Title IV-E Allowable FY_____
Net Facility/Direct Care Expense						
Indirect Administration Expense (as allocated per attached)						
GRAND TOTAL						
Total Care Days/Units Provided						
# of Licensed Beds						
Occupancy Rate						
Contracted Rate						