

**EXHIBIT 3B  
CHARITY CARE LISTING**

<b>PROVIDER NAME:</b> _____					<b>CCN:</b> _____		<b>FYE:</b> _____		<b>PREPARED BY:</b> _____					
<b>CHARITY CARE FOR (SELECT ONE):</b>								<input type="checkbox"/> <b>UNINSURED PATIENTS</b> <input type="checkbox"/> <b>INSURED PATIENTS</b>		<b>DATE PREPARED:</b> _____				
#	PATIENT CLAIM INFORMATION					UI / INC	NAME OF INSURER	MBI	MEDI-CAID NO.	CHARITY CARE DETERMINATION		GROSS CHGS	DEDUCTIBLE / COINSURANCE / COPAYMENT	
	PATIENT NAME		DATES OF SERVICE		PAT. ACCT. NO.					AP-PROVED	POLICY UNDER WHICH AP-PROVED			
	LAST	FIRST	ADM.	DIS.										
1	2	3	4	5	6	7	8	9	10	11	12	13		

CHARITY CARE LISTING (CONT.)													
NON-COV. CHGS COV. BY MEDI-CAID	MINUS (REDUCTIONS)					GROSS CHGS NET OF REDUCTIONS	ALLOW. CHAR-ITY CARE CHGS	CHAR-ITY CARE AP-PROVED RATIO	UNIN-SURED DISC-COUNT	TOTAL ALLOW. CHAR-ITY CARE AMT	WRITE OFF DATE	PAT. RESP. CHGS	PAY-MENTS RE-CEIVED
	PHYS. / PROF. CHGS	NON-COV-ERED CHGS	UNIN-SURED DIS-COUNT	CON-TRAC-TUAL AL-LOW-ANCE	COUR-TESY DIS-COUNT								
14	15	16	17	18	19	20	21	22	23	24	25	26	27