

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET G-2, PARTS I & II
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PART I - PATIENT REVENUES

REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL
		1	2	3
GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital			1
2	Subprovider IPF			2
3	Subprovider IRF			3
4	Subprovider (Other)			4
5	Swing bed - SNF			5
6	Swing bed - NF			6
7	Skilled nursing facility			7
8	Nursing facility			8
9	Other long term care			9
10	Total general inpatient care services (sum of lines 1-9)			10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive care unit			11
12	Coronary care unit			12
13	Burn intensive care unit			13
14	Surgical intensive care unit			14
15	Other special care (specify)			15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)			16
17	Total inpatient routine care services (sum of lines 10 and 16)			17
18	Ancillary services			18
19	Outpatient services			19
20	Rural Health Clinic (RHC)			20
21	Federally Qualified Health Center (FQHC)			21
22	Home health agency			22
23	Ambulance			23
24	Outpatient rehabilitation providers			24
25	ASC			25
26	Hospice			26
27	Other (specify)			27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)			28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)			29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)			43