

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET G-3
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		AMOUNT	
INCOME FROM SERVICES TO PATIENTS			
1	TOTAL PATIENT REVENUES		1
2	LESS: CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENT ACCOUNTS		2
3	NET PATIENT REVENUES		3
4	LESS: TOTAL OPERATING EXPENSES		4
5	NET INCOME FROM SERVICES TO PATIENTS		5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM COMMUNICATIONS (TELEPHONE AND INTERNET SERVICES)		8
9	REVENUE FROM TELEVISION AND RADIO SERVICES		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF SKILLED NURSING SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER MISCELLANEOUS REVENUE (SPECIFY _____)		24
25	PHE FUNDING		25
26	TOTAL OTHER INCOME		26
27	TOTAL INCOME		27
EXPENSES			
28	OTHER EXPENSES (SPECIFY _____)		28
29			29
30			30
31	TOTAL OTHER EXPENSES		31
32	NET INCOME (LOSS) FOR THE PERIOD		32