SUSTAINING RURAL LABOR & DELIVERY PROGRAMS

Strategies for Financial Analyses and Considerations for Maintaining Services

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Strategy 1: **GETTING THE MEDICARE COST REPORT RIGHT**

Strategy 2: **EVALUATING THE L&D PROGRAM CONTRIBUTION MARGIN**

Strategy 3: **CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY**

Hospitals across rural America that provide Labor & Delivery care to their communities are facing a number of challenges to sustaining local programs. Financial and operational pressures have resulted in a significant number of Labor & Delivery program closures across the nation. Since 2010, over 500 rural hospitals in the United States no longer offer Labor & Delivery.[1]

However, sometimes closure decisions may be informed by **inaccurate or incomplete financial analysis**, illustrating a need for guidance to strengthen the methods used to evaluate the sustainability of a hospital's Labor & Delivery program.

These strategies were developed to help hospital decision-makers understand the full scope of opportunities available to help keep a Labor & Delivery program open. In 2024, a Rural Maternity Innovation Summit was held to discuss innovation in rural maternity care.[2] After the summit, the Federal Office of Rural Health Policy (FORHP), Stroudwater Associates, and the Flex Monitoring Team came together with the goal of creating a guide for rural hospitals to use when assessing the financial viability of their Labor & Delivery programs. Drawing on case studies from previous Stroudwater engagements, this document outlines a series of strategies that may bring a Labor & Delivery program closer to sustainability and prevent unnecessary closure of services in rural areas that need them.

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A NOTE ON SUSTAINABILITY:

Before diving in, it is important for hospital leaders to understand that "profitability" and "sustainability" of a program can look different.

Profitability is determined by the revenue that remains after deducting all costs, including variable, direct, fixed, and overhead costs. In contrast, **sustainability** is based on contribution margin, i.e., revenue that remains after deducting program variable and direct costs only.

A program is considered sustainable if it either generates a positive contribution margin or, if operating at a loss, the loss is small enough that it does not threaten other essential programs or the organization's ability to carry out its mission.

Strategies for Sustainability

Strategy 1:

GETTING THE MEDICARE COST REPORT RIGHT

The first step to sustainability is to ensure that the Medicare Cost Report accurately captures costs to support appropriate reimbursement of Labor & Delivery care. Ensuring that costs are properly allocated can significantly increase the sustainability of the Labor & Delivery program. In the section below, Case Study 1 describes the benefits of proper cost allocation on the Medicare Cost Report.

Key Actions:

Below, we describe steps for reviewing the Cost Report to make sure that the cost of the program is appropriately reflected:

1. Understand the Cost Report Structure

The first step is to review and understand basics of the Cost Report structure and logic and its application to the Labor & Delivery program. Key Cost Report worksheets include the following:

Worksheet A: Attributes direct expenses (salary and non-salary) to departments.

Worksheet A-6: Covers reclassification of expenses/costs.

Worksheet B, Part I: Allocates costs from non-revenue producing departments to revenue producing departments based on statistics. Values are stated in terms of dollars.

CASE STUDY 1

One Critical Access Hospital (CAH) in the Western region of the United States had made the decision to discontinue their obstetrics program, primarily because of the identification of a $3.0 million loss on obstetrics services.

However, a significant portion of this apparent loss was due to a misallocation of costs. On their Cost Report, $6.0 million of obstetrics program costs had been allocated to the Labor & Delivery ancillary department, which has no cost-based reimbursement. Approximately 75% of inpatient costs for inpatient obstetrics care (when patients are not in active labor or delivery) can be allocated to the Medical-Surgical department, which receives cost-based reimbursement from Medicare.

By properly reallocating these costs to the medical-surgical cost center, the hospital would have received incremental cost-based payments of $2.5 million, which would have offset more than 80% of the initially estimated loss on the obstetrics program.

Worksheet B-1: Accumulates the statistics needed to allocate costs on Worksheet B, Part I. Values are stated in terms of dollars, square feet, pounds, etc.

For examples related to the Worksheets outlined above, please see the Appendix.

2. Determine the Appropriate Cost Allocation and Review and Revise the Cost Report as Appropriate

For hospitals that have Labor, Delivery, Recovery, and Postpartum (LDRP) rooms, the cost reporting instructions provide guidance about proper attribution of costs.[A] Specifically, the costs and statistics for inpatient Labor & Delivery care should be allocated among the Labor & Delivery and Medical-Surgical departments based on the proportion of the patient's stay in the LDRP room that the patient was receiving ancillary services (i.e., active Labor & Delivery) as opposed to routine adult and pediatric services (i.e., recovery and postpartum). Since the cost-based formula for ancillary services is different than that of general inpatient routine services, cost report misclassifications can result in lost cost-based reimbursement, especially in states that do not pay CAHs on a cost basis.

The formula to use when calculating the percentage of costs and statistics that should be allocated to the Labor & Delivery ancillary department is shown below:

> [(Time in active delivery) / (Total time of stay)] * 100 = % of Costs and Statistics Allocated to Labor & Delivery ancillary department

EXAMPLE: A patient spends ten hours in active delivery during a total stay of 50 hours. Using the formula below, 20% of costs and statistics will be allocated to the Labor and Delivery ancillary department.

> [10 hours in active delivery / 50 hours total stay] * 100 = 20% of Costs and Statistics (e.g., square feet) Allocated to Labor & Delivery ancillary department.

The remaining 80% (100% – 20%) of costs and statistics should be allocated to the Medical-Surgical Department.

For example, assume a rural hospital has a 4-bed LDRP representing the entirety of the Labor & Delivery department. If each room is approximately 450 square feet and the active Labor & Delivery time relative to the stay is 20%, then the Labor & Delivery department should have only approximately 360 square feet (450 * 4 * 20% = 360) reflected on Worksheet B-1, Line 52.

[A] "In the case where the maternity patient is in a single multipurpose labor/delivery/postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (postpartum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32." WORKSHEET S-3- HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION. Available at: https://www.costreportdata.com/instructions/Instr_S301.pdf

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Cost report items that should be evaluated for proper allocation include the following:

a. Salary & Non-Salary Expenses

Check salary and non-salary expenses on **Worksheet A, Line 52** (see section A of Appendix) to determine if they are reasonable given the understanding that the Labor & Delivery department should only reflect expenses based on the percentage of time in active delivery as a portion of the entire stay.

For example, if the entire costs of the LDRP department are included on Line 52, there may be an opportunity for improvement by reclassifying a portion of the costs to the Medical-Surgical department.[3]

b. Medical-Surgical Costs

Ensure that Medical-Surgical-related costs are appropriately reclassified to/from Labor & Delivery on **Worksheet A-6**.

Often rural hospitals will bundle costs related to the LDRP department into the Medical-Surgical department and then reclassify these costs to the Labor & Delivery department through an A-6 Reclassification. If this occurs, be sure to only include in the reclassification the portion of these costs representing the active Labor & Delivery time relative to the entire stay.

c. Statistics

Check statistics on **Worksheet B-1, Line 52 (see section B of Appendix)** to determine if they are reasonable given the understanding that the Labor & Delivery department should only reflect statistics based on the percentage of time in active Labor & Delivery relative to the entire stay. The cost drivers (i.e., statistics on Worksheet B-1) that should be evaluated (if applicable) are:

- Square feet
- Direct nursing hours
- Meal count
- FTEs
- Pounds of laundry
- Costed requisitions

d. Related Dollar Amounts

As a final check of the reasonableness of all costs allocated, review **Worksheet B, Line 52** for the dollar amounts related to the Labor & Delivery department to determine if they make general business sense given the understanding of how costs should be allocated between the Medical-Surgical department and the Labor & Delivery department.

Strategy 2:

EVALUATING THE CONTRIBUTION MARGIN OF THE LABOR & DELIVERY PROGRAM

The next step to sustainability is to understand how to correctly analyze the Labor & Delivery program from a contribution margin perspective.

A contribution margin analysis isolates all revenue and costs specific to the Labor & Delivery program by evaluating the financial performance of the entire organization assuming the Labor & Delivery program was to "go away." In some cases, the analysis may include revenues that are incidental to or downstream of the Labor & Delivery program if these revenues would not otherwise be available in the absence of the program. Case Study 2 describes the benefits of an accurate and comprehensive calculation of the contribution margin of a Labor & Delivery program.

CASE STUDY 2

A rural acute care hospital in the Southeastern region of the United States received a recommendation to close their obstetrics program based on an analysis done by the hospital's advisors. However, the analysis did not account for the resulting impact of the closure on the hospital's Medicaid payer mix. Discontinuing the obstetrics program would have reduced the hospital's disproportionate share percentage below 340B eligibility requirements. Thus, while maintaining the obstetrics program increased direct patient care losses by nearly $800K, the program enabled the hospital access to $2.5M in 340B savings due to discounted drug prices and improved the financial performance of the hospital by over $1.7M.

Key Actions:

Below we present some key elements of an accurate and comprehensive contribution margin analysis:

Identify and Quantify any Incidental Revenues

1. **Federal and State Disproportionate Share (For Rural Acute Care Facilities) and 340B**

Nationally, over 40% of births are paid for by Medicaid, and Labor & Delivery programs in rural areas often have a higher-than-average Medicaid payer mix.[4] In some cases, the Labor & Delivery program may be key to maintaining a hospital-level payer mix that:

(1) Positively impacts the Medicare Disproportionate Share (DSH) payment amount and/or determines a hospital's eligibility for Medicaid DSH, and

(2) Determines the hospital's 340B program eligibility.

For hospitals to qualify for the 340B program, they must have a Medicare DSH adjustment percentage greater than 8% for sole community providers and greater than 11.75% for non-sole community providers for the most recent cost reporting period.[5] CAHs are exempt from the "DSH" test.

Without the Labor & Delivery program, rural acute care hospitals with a number of Medicaid patients in their service area may not qualify for the enhanced Medicare DSH payments, for state Medicaid DSH payments, or for the 340B program if those patients seek care elsewhere for Labor & Delivery services and bypass the local hospital. Labor & Delivery has a high Medicaid payer mix; without the Labor & Delivery program, the hospital's share of Medicaid patients often decreases, placing them below required DSH thresholds. In addition, many state Medicaid Direct Payment programs (DPP) provide additional compensation for Labor & Delivery programs as a result of the higher Medicaid payer mix for

these programs. Because these reimbursement opportunities would be lost if the Labor & Delivery program was closed, the revenue must be considered as part of a comprehensive contribution margin analysis.

2. Incidental Services

The Labor & Delivery program may create opportunities for "spinoff" ancillaries or downstream revenues from services that are referred by the Labor & Delivery providers related to Labor & Delivery services. For example, spinoff ancillaries and downstream revenues may include:

- Ultrasounds
- Lab work
- Clinic visits
- Gynecological surgery (if the OB/GYNs currently delivering babies are also providing gynecological surgery and would leave if the hospital discontinued obstetrics)

If all or a portion of the revenues from these services would not be earned in the absence of the Labor & Delivery program, they should be included in the contribution margin analysis.

Appropriate Consideration of Costs

3. Exclusion of Non-incremental Costs

An accurate contribution margin analysis considers revenues and costs that would be different if the Labor & Delivery program was closed versus maintained.

This includes direct and variable costs only. Because most overhead costs would remain regardless of the decision to close a Labor & Delivery program, these costs should be excluded when evaluating the financial performance of the Labor & Delivery program on a contribution margin basis.

If the contribution margin is positive, the program is contributing resources to help cover the fixed and overhead costs of the hospital.

4. Proper Allocation of Operating Costs

In performing the Labor & Delivery program contribution margin analysis, appropriate allocation of fixed and "stand-by" costs is essential.

For example, if the hospital is providing 24-7 surgical services and would be doing so with or without the Labor & Delivery program, then associated fixed or stand-by costs should not be allocated to the Labor & Delivery program when evaluating contribution margin.

Stand-by costs of surgery would only be considered if the sole reason for 24-7 surgery and related costs is to support the Labor & Delivery program.

Fixed and stand-by costs may include:

- Anesthesia
- Operating room department staff
- Pediatrics
- Ancillary department

Strategy 3:

CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY OR REDUCE COSTS

The final step to sustainability is identifying creative strategies to maximize revenue or reduce overall costs of the Labor & Delivery program. Case Study 3 describes the negative impact of a lack of family practice providers on the sustainability of a Labor & Delivery program.

CASE STUDY 3

A CAH in the Southeastern region of the United States discontinued its obstetrics program because it only had one family practice provider who operated out of a Rural Health Clinic (RHC). The hospital had to call in additional providers approximately 60% of the time for obstetrics call coverage (excluding clinic visits) and thus 100% of call compensation was considered "professional" and not allowable for Cost Report purposes. Between obstetrics call compensation and the professional cost of anesthesia, the total cost to the hospital was roughly $800,000. The lack of providers to limit call coverage costs was a key factor in program closure.

Key Actions:

Below we describe several strategies that may help support the financial viability of a Labor & Delivery program:

1. **Understand Existing Opportunities for Providers and Staff**

   a. *Utilization of Family Practice Providers*

Family practice providers who are trained to provide Labor & Delivery services can support the hospital in the following ways:

- Eliminate or reduce the need for separate pediatric call coverage
- Eliminate or reduce the need for rounding expense
- Enhance the organization's primary care capacity for non-Labor & Delivery patients

   b. *Partnerships in Maintaining Competencies*

Low-volume rural Labor & Delivery programs can partner with regional medical centers to maintain provider and staff clinical competencies by providing access to the necessary volume of cases and peer learning opportunities.

2. **Understand Existing Opportunities for Partnerships with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

In states where Medicaid bundles payment for Labor & Delivery and office visits, enhanced payment for clinic visits at RHCs & FQHCs may be possible if these entities are independent of the hospital. Hospital leaders can check state guidance on payment regulation for RHCs and FQHCs to determine if a partnership would be beneficial to the program.

   a. *If your state supports additional reimbursement:*

Review state regulations on how payments are bundled and how this might impact benefits of conducting prenatal & well-baby visits in an RHC.

For FQHC partnerships, review potential benefits on Medical Malpractice Insurance Cost Reduction (as the medical malpractice insurance cost for FQHCs is significantly reduced as a result of the Federal Tort Claims Act), potential access to section 330 grant funds for expanded services, potential increases in clinic visit payments, and avoiding duplication of services to evaluate the impact of the FQHC partnership on program sustainability.

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CONCLUSION

In developing this document, the authors aim to support the long-term viability of rural Labor & Delivery programs by providing several strategies that may improve program sustainability. This framework provides information to support informed decision-making and optimize resource allocation to improve financial sustainability and ensure continued access to care.

The strategies and considerations shared in this document are designed to provide a range of opportunities that programs can pursue in the effort to sustain an obstetrics service line.

These strategies ensure that CAHs and rural hospitals understand how to properly:

- Allocate costs and statistics in the Medicare Cost Report to maximize the value created by the Labor & Delivery program.
- Evaluate the contribution margin of the program.
- Leverage other opportunities, such as partnerships and family practice providers, to enhance the efficiency of the program.

It is important to note that even if a hospital adheres to all the recommendations in this document, it may still incur a material financial loss on its Labor & Delivery program. In such cases, the question shifts to the community: how should a vital public resource be supported? The immediate next step for hospital leaders is to bring the wider community into the conversation to assess what other ways the program could be supported. State Flex Programs can be helpful to CAHs specifically in understanding challenges with services and working to connect CAHs with additional support or resources where available.

It is important for rural hospital leaders to understand that a pathway to sustainability for a Labor & Delivery program may be possible. Through the combined efforts of hospital leaders and the communities they serve, there may be avenues available to maintain this critical service.

For more information on this report, please reach out to Kristin Reiter, reiter@email.unc.edu.

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APPENDIX – Cost Report Worksheet References

A. Worksheet A

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expenses For Allocation
			1.00	2.00	3.00	4.00	5.00	6.00	7.00
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,893,239	6,893,239	119,476	7,012,715	0	7,012,715
2.00	00200	CAP REL COSTS-MVBLE EQUIP		43,048	43,048	0	43,048	-524	42,524
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	602,649	13,681,487	14,284,136	-23,236	14,260,900	0	14,260,900
5.00	00500	ADMINISTRATIVE & GENERAL	10,323,022	12,488,779	22,811,801	-815,307	21,996,494	-764,703	21,231,791
7.00	00700	OPERATION OF PLANT	1,371,629	3,135,015	4,506,644	0	4,506,644	0	4,506,644
8.00	00800	LAUNDRY & LINEN SERVICE	160,644	97,980	258,624	0	258,624	0	258,624
9.00	00900	HOUSEKEEPING	957,664	1,211,628	2,169,292	0	2,169,292	0	2,169,292
10.00	01000	DIETARY	1,171,150	1,240,110	2,411,260	0	2,411,260	-277,028	2,134,232
11.00	01100	CAFETERIA	0	0	0	0	0	-11,550	-11,550
13.00	01300	NURSING ADMINISTRATION	747,275	405,570	1,152,845	0	1,152,845	0	1,152,845
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,217,396	2,217,396	-2,055,272	162,124	0	162,124
15.00	01500	PHARMACY	1,415,920	4,556,601	5,972,521	-3,610,890	2,361,631	0	2,361,631
16.00	01600	MEDICAL RECORDS & LIBRARY	698,201	822,758	1,520,959	0	1,520,959	-9,544	1,511,415
17.00	01700	SOCIAL SERVICE	92,086	546	92,632	0	92,632	0	92,632
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,930,855	2,869,557	6,800,412	0	6,800,412	0	6,800,412
31.00	03100	INTENSIVE CARE UNIT	837,652	2,138,940	2,976,592	0	2,976,592	-309,611	2,666,981
43.00	04300	NURSERY	0	10,583	10,583	0	10,583	0	10,583
44.00	04400	SKILLED NURSING FACILITY	4,858,276	2,066,069	6,924,345	-60,884	6,863,461	-15,950	6,847,511
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,857,414	3,454,943	5,312,357	-1,138,642	4,173,715	-5,750	4,167,965
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,173,201	2,754,599	3,927,800	0	3,927,800	0	3,927,800
53.00	05300	ANESTHESIOLOGY	0	2,778,026	2,778,026	0	2,778,026	-2,676,087	101,939
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,106	2,551,597	4,914,703	205,603	5,120,306	-205,049	4,915,257
54.01	05401	CHEMO	304,897	113,858	418,755	-418,755	0	0	0
60.00	06000	LABORATORY	2,811,161	5,083,083	7,894,244	0	7,894,244	-31,680	7,862,564
60.01	06001	PATHOLOGY	134,957	258,418	393,375	0	393,375	-73,920	319,455
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	343,881	343,881	0	343,881	0	343,881
65.00	06500	RESPIRATORY THERAPY	1,103,969	762,635	1,866,604	0	1,866,604	-300,491	1,566,113
66.00	06600	PHYSICAL THERAPY	737,997	424,458	1,162,455	-192	1,162,263	0	1,162,263
67.00	06700	OCCUPATIONAL THERAPY	203,890	73,411	277,301	0	277,301	-2,603	274,698
68.00	06800	SPEECH PATHOLOGY	143,188	1,287	144,475	0	144,475	0	144,475
69.00	06900	ELECTROCARDIOLOGY	581,023	186,959	767,982	-6,987	760,995	-6,600	754,395
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,193,914	3,193,914	0	3,193,914
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,668,215	4,668,215	0	4,668,215
76.00	03610	SLEEP LAB	200,029	116,607	316,636	0	316,636	-39,708	276,928
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	0
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,696,211	5,911,572	11,607,783	844,547	12,452,330	-532,903	11,919,427

B. Worksheet B-1

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQAURE FEET)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)
		1.00	2.00	4.00	5A	5.00	7.00	9.00	11.00	13.00	16.00
	GENERAL SERVICE COST CENTERS										
1.00	00100 CAP REL COSTS-BLDG & FIXT	145,960									
2.00	00200 CAP REL COSTS-MVBLE EQUIP		145,960								
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1,743	1,743	60,452,594							
5.00	00500 ADMINISTRATIVE & GENERAL	27,996	27,996	8,916,659	-26,678,047	132,671,937					
7.00	00700 OPERATION OF PLANT	10,102	10,102	1,404,520	0	5,588,574	182,813				
8.00	00800 LAUNDRY & LINEN SERVICE	92	92	153,701	0	286,413	92				
9.00	00900 HOUSEKEEPING	3,964	3,964	1,142,671	0	2,756,536	3,964	214,613			
10.00	01000 DIETARY	2,740	2,740	1,183,463	0	2,615,681	2,740	2,740			
11.00	01100 CAFETERIA	1,926	1,926	0	0	85,037	1,926	1,926	45,145		
13.00	01300 NURSING ADMINISTRATION	5,893	5,893	763,466	0	1,415,265	5,893	5,893	607	198,095	
14.00	01400 CENTRAL SERVICES & SUPPLY	3,563	3,563	0	0	323,771	3,563	3,563	0	0	
15.00	01500 PHARMACY	1,825	1,825	1,256,581	0	2,912,204	1,825	1,825	1,213	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	3,803	3,803	471,243	0	1,467,268	3,803	3,803	718	0	357,551,482
17.00	01700 SOCIAL SERVICE	181	181	84,022	0	117,697	181	181	89	0	0
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000 ADULTS & PEDIATRICS	9,078	9,078	5,215,373	0	8,432,035	9,078	9,078	4,011	83,434	15,276,247
31.00	03100 INTENSIVE CARE UNIT	6,236	6,236	1,593,571	0	2,962,034	6,236	6,236	1,085	22,570	6,808,107
43.00	04300 NURSERY	1,000	1,000	1,373	0	62,910	1,000	1,000	0	10	1,384,634
44.00	04400 SKILLED NURSING FACILITY	8,603	8,603	5,327,515	0	9,128,532	8,603	44,459	7,196	0	11,870,889
	ANCILLARY SERVICE COST CENTERS										
50.00	05000 OPERATING ROOM	6,827	6,827	2,343,001	0	4,494,179	6,827	6,827	1,755	0	26,317,335
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,066	8,066	2,516,417	0	4,289,390	8,066	8,066	1,387	28,850	3,814,153
53.00	05300 ANESTHESIOLOGY	0	0	0	0	456,899	0	0	0	0	6,954,721

C. Worksheet B, Part I

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OUSEKEEPING	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Total
		0	1.00	2.00	4.00	5.00	7.00	9.00	11.00	13.00	16.00	26.00
	GENERAL SERVICE COST CENTERS											
00100	CAP REL COSTS-BLDG & FIXT	7,158,384	7,158,384									
00200	CAP REL COSTS-MVBLE EQUIP	53,744		53,744								
00400	EMPLOYEE BENEFITS DEPARTMENT	16,988,023	85,483	642	17,074,148							
00500	ADMINISTRATIVE & GENERAL	22,776,331	1,373,021	10,305	2,518,390	26,678,047						
00700	OPERATION OF PLANT	4,692,726	495,437	3,720	396,691	1,123,767	6,712,341					
00800	LAUNDRY & LINEN SERVICE	238,456	4,512	34	43,411	57,593	3,378					
00900	HOUSEKEEPING	2,237,933	194,408	1,460	322,735	554,293	145,546	3,456,3				
01000	DIETARY	2,146,037	134,379	1,009	334,256	525,969	100,605	44,1				
01100	CAFETERIA	-10,130	94,458	709	0	17,099	70,717	31,0	1,938,409			
01300	NURSING ADMINISTRATION	908,449	289,013	2,170	215,633	284,586	216,373	94,9	26,063	2,037,195		
01400	CENTRAL SERVICES & SUPPLY	147,717	174,742	1,312	0	65,105	130,823	57,3	0	0		
01500	PHARMACY	2,467,121	89,504	672	354,907	585,595	67,008	29,3	52,083	0		
01600	MEDICAL RECORDS & LIBRARY	1,146,259	186,512	1,400	133,097	295,043	139,635	61,2	30,829	0	1,994,023	
01700	SOCIAL SERVICE	85,022	8,877	67	23,731	23,667	6,646	2,9	3,821	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS											
03000	ADULTS & PEDIATRICS	6,510,450	445,217	3,343	1,473,025	1,695,539	333,317	146,2	172,222	858,030	85,196	12,061,051
03100	INTENSIVE CARE UNIT	2,203,816	305,835	2,296	450,087	595,615	228,967	100,4	46,587	232,108	37,969	4,309,285
04300	NURSERY	13,111	49,043	368	388	12,650	36,717	16,1	0	103	7,722	139,695
04400	SKILLED NURSING FACILITY	7,198,745	421,921	3,168	1,504,698	1,835,593	315,876	716,0	308,980	0	66,204	13,930,408
	ANCILLARY SERVICE COST CENTERS											
05000	OPERATING ROOM	3,425,065	334,820	2,514	661,780	889,627	250,667	109,9	75,355	0	146,772	5,921,805
05200	DELIVERY ROOM & LABOR ROOM	3,180,101	395,585	2,970	710,734	862,523	296,159	129,9	59,554	296,691	21,272	5,955,547
05300	ANESTHESIOLOGY	456,899	0	0	0	456,899			0	0	48,846	568,744