

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART I
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Check applicable boxes:	<input type="checkbox"/> Title V	<input type="checkbox"/> Hospital	<input type="checkbox"/> PPS
	<input type="checkbox"/> Title XVIII, Part A	<input type="checkbox"/> PARHM Demonstration	<input type="checkbox"/> TEFRA
	<input type="checkbox"/> Title XIX		

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)
	1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics (General Routine Care)							30
31	Intensive Care Unit							31
32	Coronary Care Unit							32
33	Burn Intensive Care Unit							33
34	Surgical Intensive Care Unit							34
35	Other Special Care Unit (specify)							35
40	Subprovider IPF							40
41	Subprovider IRF							41
42	Subprovider (Other)							42
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
200	Total (lines 30 through 199)							200

(A) Worksheet A line numbers