

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT				PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-3
				COMPONENT CCN: _____		
Check applicable boxes:	<input type="checkbox"/> Title V <input type="checkbox"/> Title XVIII, Part A <input type="checkbox"/> Title XIX	<input type="checkbox"/> Hospital <input type="checkbox"/> IPF <input type="checkbox"/> IRF <input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> Swing-Bed SNF <input type="checkbox"/> Swing-Bed NF	<input type="checkbox"/> ICF/IID <input type="checkbox"/> PARHM Demonstration <input type="checkbox"/> PARHM CAH Swing-Bed SNF	<input type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other	

(A)	COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3
	INPATIENT ROUTINE SERVICE COST CENTERS			
30	Adults and 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 (specify)			35
40	Subprovider IPF			40
41	Subprovider IRF			41
42	Subprovider (Specify)			42
43	Nursery			43
	ANCILLARY SERVICE COST CENTERS			
50	Operating Room			50
51	Recovery Room			51
52	Labor Room and Delivery Room			52
53	Anesthesiology			53
54	Radiology-Diagnostic			54
55	Radiology-Therapeutic			55
56	Radioisotope			56
57	Computed Tomography (CT) Scan			57
58	Magnetic Resonance Imaging (MRI)			58
59	Cardiac Catheterization			59
60	Laboratory			60
61	PBP Clinical Laboratory Services-Prgm. Only			61
62	Whole Blood & Packed Red Blood Cells			62
63	Blood Storing, Processing, & Trans.			63
64	Intravenous Therapy			64
65	Respiratory Therapy			65
66	Physical Therapy			66
67	Occupational Therapy			67
68	Speech Pathology			68
69	Electrocardiology			69
70	Electroencephalography			70
71	Medical Supplies Charged to Patients			71
72	Implantable Devices Charged to Patients			72
73	Drugs Charged to Patients			73
74	Renal Dialysis			74
75	ASC (Non-Distinct Part)			75
76	Other Ancillary (specify)			76
77	Allogeneic HSCT Acquisition			77
78	CAR T-Cell Immunotherapy			78
	OUTPATIENT SERVICE COST CENTERS			
88	Rural Health Clinic (RHC)			88
89	Federally Qualified Health Center (FQHC)			89
90	Clinic			90
91	Emergency			91
92	Observation Beds (see instructions)			92
93	Other Outpatient Service (specify)			93
93.99	Partial Hospitalization Program			93.99
	OTHER REIMBURSABLE COST CENTERS			
94	Home Program Dialysis			94
95	Ambulance Services			95
96	Durable Medical Equipment-Rented			96
97	Durable Medical Equipment-Sold			97
98	Other Reimbursable (specify)			98
200	Total (sum of lines 50 through 94 and 96 through 98)			200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)			201
202	Net charges (line 200 minus line 201)			202

(A) Worksheet A line numbers