

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE CAPITAL COSTS

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET D,
PART ICheck
applicable
boxes:
☐ Title V
☐ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☐ PARHM Demonstration

☐ PPS
☐ TEFRA

		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)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
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