APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET D, PART III

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] Hospital [ ] PARHM Demonstration [ ] PPS [ ] TEFRA [ ] Other

		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1, 2, and 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	6	7	8	9	
	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 (sum of lines 30 through 199)												200

(A) Worksheet A line numbers