

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET D, PART III
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Check applicable boxes:	<input type="checkbox"/> Title V	<input type="checkbox"/> PPS
	<input type="checkbox"/> Title XVIII, Part A	<input type="checkbox"/> TEFRA
	<input type="checkbox"/> Title XIX	<input type="checkbox"/> Other

	Nursing School Post-Stepdown Adjustments	Nursing School	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