

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		PROVIDER NO.:	PERIOD:	WORKSHEET D-4	
		_____	FROM _____		
		COMPONENT NO.:	TO _____		

Check	<input type="checkbox"/> Title V	<input type="checkbox"/> Hospital	<input type="checkbox"/> NF	<input type="checkbox"/> ICF/MR	<input type="checkbox"/> PPS
Applicable	<input type="checkbox"/> Title XVIII, Part A	<input type="checkbox"/> Subprovider	<input type="checkbox"/> Swing-Bed SNF		<input type="checkbox"/> TEFRA
Boxes	<input type="checkbox"/> Title XIX	<input type="checkbox"/> SNF	<input type="checkbox"/> Swing-Bed NF		<input type="checkbox"/> Other
COST CENTER DESCRIPTION		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
(A) INPATIENT ROUTINE SERVICE COST CENTERS					
25	Adults and Pediatrics (General Routine Care)				25
26	Intensive Care Unit				26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30	Other Special Care Unit (specify)				30
31	Subprovider				31
ANCILLARY SERVICE COST CENTERS					
37	Operating Room				37
38	Recovery Room				38
39	Delivery Room and Labor Room				39
40	Anesthesiology				40
41	Radiology-Diagnostic				41
42	Radiology-Therapeutic				42
43	Radioisotope				43
44	Laboratory				44
45	PBP Clinic Laboratory Services-Program Only				45
46	Whole Blood and Packed Red Blood Cells				46
47	Blood Storing, Processing, & Transfusing				47
48	Intravenous Therapy				48
49	Respiratory Therapy				49
50	Physical Therapy				50
51	Occupational Therapy				51
52	Speech Pathology				52
53	Electrocardiology				53
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	<i>Implantable Devices Charged to Patients</i>				<i>55.30</i>
56	Drugs Charged to Patients				56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59	Other Ancillary (specify)				59
OUTPATIENT SERVICE COST CENTERS					
60	Clinic				60
61	Emergency				61
62	Observation Beds				62
63	Other Outpatient Service (specify)				63
OTHER REIMBURSABLE COST CENTERS					
64	Home Program Dialysis				64
65	Ambulance				65
66	DME-Rented				66
67	DME-Sold				67
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)				101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)				103

(A) Worksheet A line numbers