

OUTPATIENT MEDICAID PCCM SUPPLEMENTAL WORKSHEET

PROVIDER NAME: _____	PROVIDER TPI: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART V
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Check Applicable Boxes	[] Title XIX - O/P PCCM	[] Hospital
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PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

Cost Center Description	Cost to Charge Ratio	PROGRAM CHARGES				PROGRAM COSTS				
		Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	PCCM Outpatient Program Charges	Outpatient Ambulatory Surgical Center (col. 1 x col. 2)	Outpatient Radiology (col. 1 x col. 3)	Other Outpatient Diagnostic (col. 1 x col. 4)	All Other Part B (col. 1 x col. 5)	
		1	2	3	4	5	6	7	8	
Other										0
Other										0
(A) OUTPATIENT SERVICE COST CENTERS										
60 Clinic										60
61 Emergency										61
62 Observation Bed										62
63 Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										
64 Home Program Dialysis										64
65 Ambulance										65
66 Durable Medical Equipment-Rented										66
67 Durable Medical Equipment-Sold										67
68 Other Reimbursable Cost Center										68
101 Subtotal (see instructions)										101
102 CRNA Charges (see instructions)										102
103 Less PBP Clinic Lab. Services-Program Only Charges										103
104 Net Charges (line 101 ± lines 102 and 103)										104