

INPATIENT MEDICAID PCCM SUPPLEMENTAL WORKSHEET

PROVIDER NAME: _____		PROVIDER TPI: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-4
Check Applicable Boxes	<input type="checkbox"/> Title XIX I/P PCCM	<input type="checkbox"/> Hospital		
COST CENTER DESCRIPTION		Ratio of Cost To Charges	PCCM Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3
	Other			0
	Other			0
	Other			0
	Other			0
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