TENTATIVE SETTLEMENT

HOSPITAL NAME			
HOSPITAL NUMBER			
REPORTING PERIOD		THROUGH	
SETTLEMENT DATA PERIOD		THROUGH	
AUDITED C/R (YES/NO)			
COMPLETED BY (INITIALS)			
DATE COMPLETED			
ENTER YEAR OF SETTLEMENT (i.e. 1993)			
DRG HOSPITAL (Y/N)			

SUBMITTED COST REPORT

I/P ROUTINE SERV COST PER DIEM	WKST D-1 LINE 38	
MEDICAID I/P ANCILLARY SERV COST	WKST D-1 LINE 48	
I/P EXCLUDABLE COST	WKST D-1 LINE 52	
TOTAL COST EXCL CAPITAL	WKST D-1 LINE 53	
O/P COST	WKST D Part V Column 9	
O/P CHARGES	WKST D Part V Column 5	
Submitted Cost To Charge	Calculated	0.00% does not include HBF
CAPITAL REDUCTION	WKST S-2 LINE 38.02	

SETTLEMENT DATA INFORMATION

MEDICAID DAYS (TOTAL)	
MEDICAID DISCHARGES	
TOTAL INPATIENT CHARGES	
TOTAL INPATIENT PAYMENTS	
TOTAL OUTPATIENT CHARGES	
TOTAL OUTPATIENT PAYMENTS (please complete section below)	$ -
RENAL PAYMENTS(excluded from above) - please complete section below	$ -
SNF PAYMENTS (excluded from above)	
ADD BACK OF INPAT. CHARGES FROM NON-REIMB TO REIMB.	
ADD BACK OF OUTPAT. CHARGES FROM NON-REIMB TO REIMB.	

MISC

YEAR END OF THE FINAL SETTLEMENT BEING USED FOR AMOUNTS BELOW (I.e. 2000, 2001)			
I/P HOSP BASED PHY	PER PRIOR YEAR FINAL SETTMNT WKST		
O/P HOSP BASED PHY	PER PRIOR YEAR FINAL SETTMNT WKST		
TEFRA TARGET AMOUNT	DRG TEFRA LISTING	G:\depts\PROVREMB\Staffs\New Jersey\Medicare\Rate Schedules - Reimbursement\TEFRA\CAID_TGT_DRG.xls	
	NON-DRG TEFRA LISTING	G:\depts\PROVREMB\Staffs\New Jersey\Medicare\Rate Schedules - Reimbursement\TEFRA\CAID_TGT_Non_Drg.xls	
O/P COST TO CHG RATIO	BASED ON ANALYSIS FROM DMAHS		rate includes HBP

FINANCIAL FILE

Inpatient	Outpatient

OTHER:	DATE:		AMOUNT		
OTHER:	DATE:		AMOUNT		

TENTATIVE SETTLEMENT - Review of Renal Payments

Provider _____

Number _____

FYE _____

Outpatient Payments from Settlement data

Calculation of Outpatient Renal Payments			Providers		C/Y Allowable	
		Total XIX Charges	P/Y Unit Charge	Units	Rate	Medicaid Pmt rate
Rev Code	634			-	$ 40.00	$ -
Rev Code	635			-	$ 70.00	$ -
Rev Code	80X			-		$ -
Rev Code	81X			-	$ -	$ -
Rev Code	82X			-	$ -	$ -
Rev Code	83X			-	$ 20.00	$ -
Rev Code	84X			-	$ -	$ -
Rev Code	85X			-	$ -	$ -
Total Outpatient Renal Payments		$ -				

Net Outpatient Payments

WKST D-1 CALCULATION

1. MEDICAID I/P COSTS	(WKST D-1 LINE 38 x MEDICAID DAYS) + WKST D-1 LINE 48
2. TOTAL EXCLUDABLE COST	WKST D-1 LINE 52
3. TOTAL I/P COST LESS EXCLUDABLE COST	Calculated
4. PROGRAM DISCHARGES	SETTLEMENT DATA
5. TARGET AMOUNT PER DISCHARGE	RGBA LISTING
6. TARGET AMOUNT	LINE 4 X 5
7. DIFFERENCE	LINE 6 - LINE 3
8. INCENTIVE AMOUNT	
A. IF LINE 7 > ZERO	LESSOR OF (LINE 6 X .02) OR (LINE 7 X .15)
B. IF LINE 7 < ZERO	LESSOR OF (LINE 6 X .10) OR (.5 X (LINE 3 - (1.10 X Line 6)))
9. ALLOWABLE I/P COST + INCENTIVE	(LINE 2 +LINE 8A OR 8B)+LESSOR OF LINE 3 OR 6

TENTATIVE SETTLEMENT
NEW JERSEY MEDICAID PROGRAM
TITLE XIX (MEDICAID) SETTLEMENT WORKSHEET

HOSPITAL NAME: _____ **HOSPITAL NO:** _____
CLAIMS PAID FROM: _____ **PERIOD:** _____
PREPARED BY: _____ **DATE:** _____

		INPATIENT
1. Inpatient hospital allowable cost	Recalculation of wkst D-1	$0
2. Outpatient hospital allowable cost	DMAHS CTC % X Settlement data charges	
3. Hospital Based Physician	75% of prior year audited C/R if submitted CTC is used	$0
4. Total costs	SUM OF LNS 1 THRU 3	$0
5. Less: Excess of cost over charges	LINE D -- SEE BELOW	$0
6. Reimburseable cost allowed	LN 4 - LN 5	$0
7. Less: O/P 5.8% reduction	Line 4 x 5.8% - unless costs>charges, or DMAHS CTC used	N/A
8. Adjusted cost allowed under program	LN 6 - LN 7	$0
9. Less: Settlement data payments	Settlement data	$0
10. Other settlement	Financial file	$0
11. Balance: (over) underpayment	LN 8 - LN 9 - LN 10	$0
12. Tentative settlement %	75% for underpayment,; 100% overpmt	X 1.00
13. Tentative settlement amount	INPATIENT + OUTPATIENT	$0

ELIGIBLE CHARGE LIMITATION

Inpatient:

A. Total cost for comparison	LN 6 - LN 3	$0
B. Total reasonable charges + incentive	SETLMNT DATA + CALC INCENT - D-3 (HBP)	$0
C. Excess of charges over cost	LN B - LN A	$0
D. Excess of cost over charges	LN A- LN B	$0

Outpatient:

A. Total cost for comparison	LN 6 - LN 3	$0
B. Total charges	SETTLEMENT DATA LESS D-3	$0
C. Excess of charges over cost	LN B - LN A	$0
D. Excess of cost over charges	LN A- LN B	$0

MEDICAID SETTLEMENT SUMMARY SHEET

HOSPITAL NAME:
HOSPITAL NBR:
REPORTING PERIOD:
SETLMNT DATA PERIOD:
DATE COMPLETED:
COMPLETED BY:
SETTEMENT TYPE: **TENTATIVE SETTLEMENT**

MEDICAID DAYS		0
MEDICAID DISCHARGES		0
NET ALLOWABLE COST	INPATIENT	$0
NET ALLOWABLE COST	OUTPATIENT	$0
SUBMITTED I/P PER DIEM (NON DRG ONLY)		n/a
SUBMITTED COST TO CHARGE RATIO (based on Net Allowable Costs)		n/a
SETTLEMENT AMOUNT	INPATIENT	$0
SETTLEMENT AMOUNT	OUTPATIENT	$0
TOTAL SETTLEMENT AMOUNT		$0

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$	-
$	-

0.00
0.00
0.00
0
0.00
0.00
0.00
0.00
0.00
$0

OUTPATIENT
[redacted]
$0
$0
$0
$0
$0
$0
$0
$0
$0
$0
X 1.00
$0