

260011 - 2017/07

Office of Medicaid Cost Reimbursement Planning and Finance

2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Florida State Hospital | | Provider Number: 0260011-00 | | | |
|------------------------|--------------------------------------|-----------------------------|----------------------------|----------------------------------|--|
| Building 260 | | Date: 6/30/2017 | | | |
| Chattahoochee, FL 3232 | 4- | Fiscal Year End: 6/30/2016 | | | |
| | | | Audit Status: | Jnaudited Cost Report | |
| Provider Type: | | | | | |
| HOSF | PITAL | Current Rate | New Rate | Effective Date | |
| | Inpatient | 482.92 | 300.66 | 7/1/2017 7/1/2017 7/1/2017 | |
| C | Outpatient | 13.04 | 0.00 | | |
| Inpatient Coun | ty Billing Rate | | | | |
| Rate Type: | | | | | |
| Interim | | X <u>Pros</u> | spective | | |
| | Total Interim | | X Total Prospecti | ve | |
| | Settlement Based | on Cost | <u> </u> | | |
| | <u> </u> | | | | |
| | | BASIS : | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Costs | | | |
| | | Revised Field Audit | | | |
| | | Cost Report Late Test | | | |
| | | | | | |
| | | | | TR NO | |
| | | W. Rydell S | amuel or Jesse Bottcher | A Jo | |
| | | Medicaid Co | ost Reimbursement Analys | sis | |
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| | | | For Information only | y - No Change in rate | |
| Batch ID:XJ52F | | | Printed on : 7/5/2017 8:57 | AM | |



260029 - 2017/07

Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Northeast Flori | ida State Ho | ospital | | | | Provider Number: | 0260029-00 | | | |
|-------------------------|----------------|--------------|--------------------------------------|----------------------------------|------------------|---------------------|-------------------------|--|--|--|
| HWY 121 SOL | JTH | | | | | Date: | 6/30/2017 | | | |
| Macclenny, FL 32063- | | | | | Fiscal Year End: | 6/30/2016 | | | | |
| , | | | | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Ty | pe: | | | | | | | | | |
| | <u>HOSP</u> | <u> ITAL</u> | | Current Ra | <u>te</u> | New Rate | Effective Date | | | |
| Inpatient Outpatient | | | | 328.38 13.04 | | 320.89 | 7/1/2017 | | | |
| | | | | | | 0.00 | 7/1/2017 | | | |
| Inpatie | ent Count | y Billing | Rate | | | | 7/1/2017 | | | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | Х | <u>Prospecti</u> | <u>ve</u> | | | | |
| | | Total Inte | erim | | X | Total Prospec | etive | | | |
| | | Settleme | nt Based on | Cost | | | | | | |
| | | | | | _ | | | | | |
| | | _ | | BASIS | <u>S:</u> | | | | | |
| | | - | V | Budget - | ha. | | | | | |
| | | - | Х | Unaudited Cost - Field Audited C | | | | | | |
| | | _ | | Revised Field A | | | | | | |
| | | - | | Cost Report La | | | | | | |
| | | - | | - - | 10 1001 | | | | | |
| | | | | W. F | Rydell Samue | l or Jesse Bottchei | JE JE | | | |
| | | | Medicaid Cost Reimbursement Analysis | | | | | | | |
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| Datab ID VISOE | | | | | | - | 7 ^ ^ ^ | | | |

Batch ID:XJ52F

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260045 - 2017/07

Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

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|---|----------------|---------------|--------------------|--|-----------------------------|------------------------|-------------------------|--|
| South Florida State Hospital 800 East Cypress Dr | | | | | Provider Number: 0260045-00 | | | |
| | | | | | Date | 6/30/2017 | | |
| Pembroke Pines, FL 33025- | | | | Fiscal Year End: 6/30/2016 | | | | |
| | | | | | | Audit Status | : Unaudited Cost Report | |
| Provider Ty | ype: | | | | | | | |
| - | HOSF | PITAL | | <u>Curre</u> | nt Rate | New Rate | Effective Date | |
| Inpatient Outpatient | | | | 23 | 1.27 | 182.47 | 7/1/2017 | |
| | | | t | 13.04 | | 0.00 | 7/1/2017 | |
| Inpatie | ent Count | ty Billing | Rate | | | | 7/1/2017 | |
| Rate Type: | | | | | | | | |
| rtate Type. | <u>Interim</u> | | | | X Pros | spective | | |
| | _ | Total Inte | erim | _ | | X Total Prospec | ctive | |
| | | – Settleme | ent Based or | n Cost | | <u> </u> | | |
| | - | | | | | | | |
| | | | | <u> </u> | BASIS: | | | |
| | | | | Budget | | | | |
| | | | Х | — Unaudited | d Costs | | | |
| | | | | Field Aud | ited Costs | | | |
| | | | | Revised F | Field Audit | | | |
| | | | | Cost Rep | ort Late Test | | | |
| | | | | | | | | |
| | | | | | W. Rydell S | amuel or Jesse Bottche | r # 18 | |
| | | | | | Medicaid Co | ost Reimbursement Ana | lysis | |
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Batch ID:XJ52F



260053 - 2017/07

Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Mark Flavida O | · | Sana Cantan | | | Pi | rovider Number: | 0260053- | .00 | |
|------------------|----------------|------------------|--------------------------------------|---------------|-----------------|---------------------|-------------|----------------|--|
| West Florida C | - | care Center | | | • | | 6/30/2017 | | |
| 5500 Stewart St. | | | | | F | Fiscal Year End: | | | |
| Milton, FL 325 | 070- | | | | • | | | d Cost Report | |
| D | | | | | | | | | |
| Provider Ty | - | I T | C | of Doto | | New Date | - | Effective Date | |
| | HOSP | | | nt Rate | 184.73 | | 7/1/2017 | | |
| | | npatient | | 3.25 | | | | | |
| Outpatient | | | 13 | .04 | 0.00 | | 7/1/2017 | | |
| Inpatie | ent Count | y Billing Rate | | | | | | 7/1/2017 | |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | X Pros | <u>spective</u> | | | | |
| | | Total Interim | | | Χ | Total Prospec | tive | | |
| | | Settlement Based | on Cost | | | | | | |
| | | | _ | | | | | | |
| | | | | ASIS: | | | | | |
| | | | Budget | _ | | | | | |
| | | X | Unaudited | | | | | | |
| | | | Field Audi | | | | | | |
| | | | Revised F | | | | | | |
| | | | Cost Repo | ort Late Test | | | | | |
| | | | | | | | | - 0 | |
| | | | | | | | IK | 3 NB | |
| | | | | W. Rydell S | amuel o | r Jesse Bottcher | FU | | |
| | | | Medicaid Cost Reimbursement Analysis | | | | | | |
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| | | | | | | or Information or | iiy - NO Ch | ange in fale | |
| Batch ID:XJ52F | | | | | Printe | ed on: 7/5/2017 8:5 | 7 AM | | |