



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2020 through June 30, 2021

260011 - 2020/07
301.89 / 0.00

Type of Control: Government

Florida State Hospital

County: Gadsden (20)

Fiscal Year: 7/1/2018 - 6/30/2019

Type of Action: Amended Cost Report

District: 2

Hospital Classification: Special

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	0.00	0.00	0.00	0.00	Total Bed Days	12,410
2. Routine	4,872,642.00		4,033,784.00		Total Inpatient Days	11,675
3. Special Care	0.00		0.00		Total Newborn Days	0
4. Newborn Routine	0.00		0.00		Medicaid Inpatient Days	9,665
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	0
6. Home Health					Medicare Inpatient Days	0
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0553116769
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	0
9. Total Cost	4,872,642.00	0.00	4,033,784.00	0.00	Property Rate Allowance	1.00
10. Charges	4,872,642.00	0.00	4,033,784.00	0.00	First Rate Semester in Effect	2020/07
11. Fixed Costs	1,125.00		931.32		Last Rate Semester in Effect	2020/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	4.67		0.00	County Ceiling Base	Exempt	Exempt
2. Base Rate Semester	2020/07	2020/07	Variable Cost Base	Exempt	Exempt	Cost Report DRI Index	2.2780
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	0.00	0.00	FPLI Year Used	2018
4. Rate of Increase (Year/Sem.)	1.019294	1.042606	County Ceiling	0.00	0.00	FPLI	94.2800

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	4,033,784.00	0.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	931.32	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	4,032,852.68	0.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	4,255,916.52	0.00
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	9,665	0
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	440.34	0.00
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	440.34	0.00
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (94.2800) for Gadsden (20)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	440.34	0.00
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	0.10	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	440.44	0.00
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	4,033,784.00	0.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	417.36	0.00
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	440.44	0.00
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	440.44	0.00
AU	(IP%: 31.4582 %, OP%: 25.6234 %)	(138.55)	0.00
AV			
AW			
AX			
AY	Final Prospective Rates	301.89	0.00



Florida Agency for Health Care Administration
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 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2020 through June 30, 2021

260029 - 2020/07
145.51 / 0.00

Northeast Florida State Hospital

Type of Control: Government

County: Baker (2)

Fiscal Year: 7/1/2018 - 6/30/2019

Type of Action: Unaudited Cost Report

District: 4

Hospital Classification: Special

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	2,780,961.00	0.00	105,543.00	0.00	Total Bed Days	21,900
2. Routine	7,804,389.00		3,091,267.00		Total Inpatient Days	21,684
3. Special Care	0.00		0.00		Total Newborn Days	0
4. Newborn Routine	0.00		0.00		Medicaid Inpatient Days	8,589
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	0
6. Home Health					Medicare Inpatient Days	0
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0553116769
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	0
9. Total Cost	10,585,350.00	0.00	3,196,810.00	0.00	Property Rate Allowance	1.00
10. Charges	10,585,350.00	0.00	3,196,810.00	0.00	First Rate Semester in Effect	2020/07
11. Fixed Costs	211,704.00		63,935.29		Last Rate Semester in Effect	2020/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	3.97		0.00	County Ceiling Base	Exempt	Exempt
2. Base Rate Semester	2020/07	2020/07	Variable Cost Base	Exempt	Exempt	Cost Report DRI Index	2.2780
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	0.00	0.00	FPLI Year Used	2018
4. Rate of Increase (Year/Sem.)	1.019294	1.042606	County Ceiling	0.00	0.00	FPLI	96.9100

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	3,196,810.00	0.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	63,935.29	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	3,132,874.71	0.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	3,306,159.26	0.00
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	8,589	0
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	384.93	0.00
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	384.93	0.00
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (96.9100) for Baker (2)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	384.93	0.00
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	7.44	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	392.37	0.00
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	3,196,810.00	0.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	372.20	0.00
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	392.79	0.00
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	392.37	0.00
AU	(IP%: 31.4582 %, OP%: 25.6234 %)	(123.43)	0.00
AV	(IP%: 31.4582 %, OP%: 25.6234 %)	(123.43)	0.00
AW			
AX			
AY	Final Prospective Rates	145.51	0.00



Florida Agency for Health Care Administration
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 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2020 through June 30, 2021

260045 - 2020/07
184.10 / 0.00

Type of Control: Government

County: Broward (6)

Fiscal Year: 7/1/2018 - 6/30/2019

Type of Action: Unaudited Cost Report

District: 10

Hospital Classification: Special

South Florida State Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	337,101.00	0.00	0.00	0.00	Total Bed Days	18,250
2. Routine	4,552,320.00		492,073.00		Total Inpatient Days	17,855
3. Special Care	0.00		0.00		Total Newborn Days	0
4. Newborn Routine	0.00		0.00		Medicaid Inpatient Days	1,930
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	0
6. Home Health					Medicare Inpatient Days	0
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0553116769
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	0
9. Total Cost	4,889,421.00	0.00	492,073.00	0.00	Property Rate Allowance	1.00
10. Charges	4,889,421.00	0.00	492,073.00	0.00	First Rate Semester in Effect	2020/07
11. Fixed Costs	164,253.00		16,530.48		Last Rate Semester in Effect	2020/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	2.54		0.00	County Ceiling Base	Exempt	Exempt
2. Base Rate Semester	2020/07	2020/07	Variable Cost Base	Exempt	Exempt	Cost Report DRI Index	2.2780
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	0.00	0.00	FPLI Year Used	2018
4. Rate of Increase (Year/Sem.)	1.019294	1.042606	County Ceiling	0.00	0.00	FPLI	102.4100

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	492,073.00	0.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	16,530.48	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	475,542.52	0.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	501,845.58	0.00
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	1,930	0
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	260.02	0.00
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	260.02	0.00
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (102.4100) for Broward (6)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	260.02	0.00
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	8.57	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	268.59	0.00
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	492,073.00	0.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	254.96	0.00
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	269.06	0.00
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	268.59	0.00
AU	(IP%: 31.4582 %, OP%: 25.6234 %)	(84.49)	0.00
AV			
AW			
AX			
AY	Final Prospective Rates	184.10	0.00



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 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2020 through June 30, 2021

260053 - 2020/07
213.92 / 0.00

West Florida Community Care Center

Type of Control: Government

County: Santa Rosa (57)

Fiscal Year: 7/1/2018 - 6/30/2019

Type of Action: Unaudited Cost Report

District: 1

Hospital Classification: Special

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	2.00	0.00	0.00	0.00	Total Bed Days	36,500
2. Routine	8,161,649.00		108,066.00		Total Inpatient Days	27,567
3. Special Care	0.00		0.00		Total Newborn Days	0
4. Newborn Routine	0.00		0.00		Medicaid Inpatient Days	365
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	0
6. Home Health					Medicare Inpatient Days	1,005
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0553116769
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	0
9. Total Cost	8,161,651.00	0.00	108,066.00	0.00	Property Rate Allowance	1.00
10. Charges	8,161,651.00	0.00	108,066.00	0.00	First Rate Semester in Effect	2020/07
11. Fixed Costs	169,792.00		2,248.17		Last Rate Semester in Effect	2020/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	3.16		0.00	County Ceiling Base	Exempt	Exempt
2. Base Rate Semester	2020/07	2020/07	Variable Cost Base	Exempt	Exempt	Cost Report DRI Index	2.2780
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	0.00	0.00	FPLI Year Used	2018
4. Rate of Increase (Year/Sem.)	1.019294	1.042606	County Ceiling	0.00	0.00	FPLI	96.9200

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	108,066.00	0.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	2,248.17	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	105,817.83	0.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	111,670.80	0.00
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	365	0
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	305.95	0.00
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	305.95	0.00
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (96.9200) for Santa Rosa (57)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	305.95	0.00
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	6.16	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	312.11	0.00
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	108,066.00	0.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	296.07	0.00
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	312.45	0.00
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	312.11	0.00
AU	(IP%: 31.4582 %, OP%: 25.6234 %)	(98.18)	0.00
AV			
AW			
AX			
AY	Final Prospective Rates	213.92	0.00

